

Towards Comprehensive Women's Health Programmes and Policy

SAHAJ
for
Women & Health (WAH!)

Edited by
Renu Khanna, Mira Shiva
Sarala Gopalan

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Second Edition, 1977

Edited by
Sri K. K. Srinivas, M. S. Srinivas
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Towards Comprehensive Women's Health Programmes and Policy

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for
Women & Health (WAH!)

Edited by
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Sarala Gopalan

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Published by : Society for Health Alternative (SAHAJ) for WAH!, 2002

Editors : Renu Khanna, Mira Shiva, Sarala Gopalan

Funding Support : UNFPA, New Delhi, India
Stiftung Umverteilen, Berlin, Germany

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Designed and Typeset : Page Setter
31, Sampatrao Colony, Alkapuri, Vadodara
Printed at : Page Setter
31, Sampatrao Colony, Alkapuri, Vadodara
Cover Design : Ajay Sharma

HEALTH

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Preface

A Background to WAH! and the Book

WAH! or the Women and Health initiative emerged out of a concern that the primary health care concept failed to consider gender issues and the specific health needs of women in the provision of health care. The seeds of WAH! were sown during 1992, when critical stakeholders from the national level came together in Surajkund in November to review primary health training needs in India. It was collectively decided that capacity building for women in primary health care management was need of the hour.

Although the WAH! programme began with a focus on training, it expanded over the years to include the goals of advocacy and networking as well. Networking, we realised, was very important, especially in the context of the rapid changes taking place at both the macro and micro levels. Today, there is an even greater need for building strategic alliances and collaboration to build momentum and consolidate the efforts of diverse women's training activities.

WAH! thus developed into a multi-regional programme for promoting comprehensive, gender-sensitive and sustainable primary health care for all, with special emphasis on women, girl children and other disadvantaged persons, throughout their life cycle. WAH! also built on and promoted sound local health and healing practices. WAH! was started as a training programme for health coordinators and supervisors working in the area of women's health. As a collective endeavour of individuals and NGOs, WAH! initiated its activities guided by a small core group and today has the potential to establish itself as a strong network. Though WAH! was conceived, and is monitored, at a national level, the training interventions are conducted at regional levels. This two-tiered approach has helped build and enrich the process of training even as it continues to provide several opportunities to share the WAH! perspective at the national policy level.

This book is a result of a process which culminated in a national consultation entitled 'Towards Comprehensive Women's Health Policy and Programmes' in February 1999. We felt that the papers presented and the discussions held at this consultation would be of interest to a wider audience. However, the consultation was only the starting point for the book – we have added several chapters and sections on to the programme of the original consultation. The two-day consultation brought together grassroots workers and representatives from NGOs working on women's health and related issues, as well as senior academicians and researchers working in different sectors affecting various dimensions of women's lives. Senior officers from departments of Health and Family Welfare and Women and Child Development were also present. Representatives of donor agencies and experts on media advocacy and women's studies also participated. The issues discussed ranged from National and State Policies for the Empowerment of Women, Reproductive Health Policy and Programme, Traditional Systems of Medicines and Women's Health, Laws Affecting Women's Health and Women in Panchayati Raj Institutions to Gender Issues in Medical Education, Training for Women's Health and how different policies (like Economic, Education, Drug) affect women's health. The background papers provided rich insights and formed the basis for passionate debates.

The discussions reiterated that health care and development policies and programmes must ensure gender justice and equity in health. Women's participation in policy decisions that affect their lives and their health is essential and that programmes and processes that facilitate women's participation in policy formulation would need to be nurtured.

WAH! Perspective

WAH! follows the principle of participatory approach keeping local and regional needs in view. The process began in 1990 when an independent consultant was engaged to assess the health training needs in both India and Nepal. Based on this assessment, a planning workshop on 'Management of Primary Health Care Programmes' was held in November 1992. The objective was to develop a framework for comprehensive training aimed at strengthening the organisational and management capacity of women in NGOs implementing PHC programmes with a focus on women's health. The emerging need for capacity building in the area of women's health attracted key national-level stakeholders to participate in the workshop. Discussions among them provided insights to develop modules on:

- Understanding women's health concerns.
- Building women's capacities in PHC and women's health care.
- Enabling and enhancing women's health programme management.

In July 1993, at a workshop in Bangalore, interested women's groups, health trainers, academicians, NGO representatives, and others working in women's health and development were invited for a national-level consultation. The event provided an enabling platform for sharing mutual concerns and experiences in the area of women's health. At the end of a six-day deliberation, an outline for the three modules was developed. A decision was taken to train middle-level supervisory staff from NGOs at the regional rather than the national level. At this stage, WAH! began the process of supporting the development of the Southern Region training programme guided by the WAH! perspective. This was later fine-tuned into an 'Approach Document' which has subsequently guided all WAH!

activities.

The WAH! perspective drew its inspiration from

- the international women's health movement and the shape it has taken in South Asia;
- local healing traditions and indigenous systems of medicine;
- experiences of community development, primary health care, rational therapy and consumer rights movements;
- the lives and insights of the poor, marginalised and oppressed women.

Intellectually, the effort has been guided by the scientific underpinnings of epidemiology and the spirit of medicine - both modern and traditional.

Developing the Curriculum

During the 1993 workshop, a core group was formed take the WAH! activities forward. The group met regularly to share and discuss experiences and learnings, based on which decisions were taken to facilitate the WAH! process. The members also contributed to the WAH! training efforts, documentation and material development.

A participatory approach was used to develop the WAH! training programme. The process adopted in the pilot phase and the learnings that emerged from this phase were analysed and modified to suit other state-level training efforts. Each step of the pilot training programme provided a unique opportunity to build on earlier learnings. It also helped to develop and strengthen the WAH! network.

The Pilot Programme

The pilot WAH! training for the Southern region was developed and organised by Aikya, Bangalore, for the states of Karnataka and Tamil Nadu during 1994-95. The formal evaluation of the Southern region pilot WAH! training proved to be positive and encouraging. It reaffirmed the need for such training and provided strength and motivation to all of us to take the WAH! agenda forward. It also provided guidance for such practical issues as the selection of participants, training content, duration

of the training and training methodology.

The pilot training threw up two major challenges for the WAH! programme. One was the interfacing of traditional health practices with modern medicine and the other was the need to address the social and political linkages related to women's health and development issues.

Curriculum Revision

Based on the experiences of WAH! pilot training, a curriculum revision workshop was held to discuss the possibility of interfacing traditional health care with modern medicine. Apart from the WAH! regional representatives, practitioners and academicians interested in the subject also participated in the workshop. As a result, a unique set of people came together: although trained in different streams of health care, they were all committed to holistic health and working towards the improvement of women's health. After extensive discussions, the group felt the need to develop guidelines for diagnosis and treatment at the Primary Health Care level.

Western Region WAH! Training

Synthesising the experiences of WAH! pilot programme and the curriculum revision workshop during 1997-98, CHETNA took up the challenge of organising the training for two states, Gujarat and Rajasthan. The planning and execution of WAH! Western region training also followed a participatory approach. Efforts were made to address the concerns expressed about the pilot project, namely, duration of training, selection of participants, integration of the gender component, etc. The involvement of the Southern region trainers in planning the training for the Western region greatly enriched the learning in terms of knowledge and methodology.

Maharashtra WAH! Programme

The WAH! Programme in Maharashtra, MAHWAH, was the third regional training and advocacy initiative in India. Launched in early 1998, MAHWAH completed its training programme in April 2000. Twenty-six middle-level workers from 18 NGOs in 11 districts of Maharashtra were

trained during the programme. Through this intensive process, a regional forum of the participating NGO has been formed. Forum members interact and support each other on health issues of common concern.

MAHWAH was a partnership between three organisations or groups: MASUM, Pune, which was the Training Unit; Pragati Foundation, Pune, the Financial Management Unit; and Mira Sadgopal and colleagues (who later evolved into an organisation called Tathapi) who were the Documentation Unit.

Advocacy Efforts by WAH!

As mentioned earlier, in addition to training, advocacy for comprehensive women's health programmes has also been a consistent effort of WAH! Through WAH! training, the participants of regional programmes have been encouraged to reach local women's voices to district and state health authorities. In addition, state-level advocacy efforts have been organised by the WAH! Core Group members in their respective states. The National Consultation mentioned earlier, 'Towards Comprehensive Women's Health Policy and Programmes', was organised in February 1999 in recognition of the fact that the rapidly changing economic, social and political context is adversely affecting women's lives and health status. In this context, the WAH! Core Group felt that it would be necessary to do a collective, multi-sectoral analysis of how different policies and programmes of the Government of India affect women's health, especially the health of poor and marginalised women. The Consultation was organised by the WAH! Core Group in partnership with Voluntary Health Association of India and DSE (German Foundation for International Development). VHAI was a natural partner in this effort for comprehensive women's health policies and programmes. VHAI has been deeply concerned about the state of India's health. Two significant reports brought out by VHAI – 'The State of India's Health' and the 'Independent Commission on Health' – have tried to highlight the critical issues in women's health. Various publications and training programmes conducted by the organisation have reflected their concern about gender issues in women's health. Through the National Consultation and its follow-up,

VHAI hoped that certain policy advocacy efforts would be set in motion that would help women and other marginalised groups to access their health rights. DSE, or the German Foundation for International Development (1959), is one of the oldest organisations in Germany and was founded with its primary focus on issues of development. In recent years, it has focused on training and capacity building, for health and development work in developing countries. Recognising the lack of women in managerial position for health and development work, DSE has focused on strengthening women's organisational and managerial capabilities. As mentioned previously, all the WAH! regional training programmes were supported by DSE and DSE also decided to be a partner in this consultation.

We thank DSE for its support and partnership. The contribution of many others, both intellectually and materially, for making the book possible is gratefully placed on record (see Acknowledgements).

We hope the present book itself has been worth the effort. It is now for the readers to decide!

Renu Khanna, Mira Shiva, Sarala Gopalan

February 2002

Editors' Note

As in any collection that brings together papers written by different authors, one of the primary challenges in preparing this book has been in the task of systematising different styles, notes and bibliographic references. Throughout the volume, we have sought to preserve the spirit of the original papers. We have tried to adapt notes and references to conform to a uniform style. When possible, we have tried to update references and offer complete bibliographic information, though we regret we may not have always been able to do so successfully. Whenever in doubt, however, we have been guided by the authors' originals and have attempted throughout, to stay in tune with the authors' intentions.

This book has been in the making for a number of years. Several events have delayed the production of the volume. Notable amongst these are the earthquake in Gujarat in January 2001 and the Gujarat carnage from February to May 2002. While we apologise for the delay, we are also glad that we had the opportunity to include debates around major national policies that took place in the country through 2001.

Acknowledgements

We warmly acknowledge the contribution of the following

- Voluntary Health Association of India and German Foundation for International Development (DSE), the original partners in the National Consultation 'Towards Comprehensive Women's Health Policy and Programmes.'
- All the authors for agreeing to publish their papers in this volume.
- UNFPA (New Delhi) and Women of Stiftung Umverteilen (Berlin) for providing the financial support.
- Sarita Vellani, Yamini Venkatchalam and Mira Sadgopal for their help in editing the manuscript.
- Rita Parmar, V. Balakrishnan, Padmini Krishnan and C.P. Shastry and Mr. Raman for secretarial support.

Mr. S. Gopalan and Mr. Chinu Srinivasan for their moral and other support in the many moments of frustration.

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*Chapter 1***Introduction**

Renu Khanna and Mira Shiva

Throughout the world, women and girls have not enjoyed equal access to basic human rights, protections, resources and services. In the last two decades there have been major international efforts directed at eradicating discrimination against women and promoting their development and well-being. In the 1970s, prodded by a strong feminist movement which demanded changes in global policy-making in areas affecting women's lives, there were several major international conferences and conventions.

Policy Environment Created by International Conferences

The 1975 United Nations Conference on Women, held in Mexico City, launched the United Nations Decade on Women. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted in 1979. The 1980 United Nations Conference on Women, Copenhagen, was held at the midpoint of the Decade on Women to assess progress. And in 1985, the United Nations Conference on Women was held in Nairobi at the end of the UN Decade on Women where 'The

Nairobi Forward-Looking Strategies for the Advancement of Women to the Year 2000' was created. The Earth Summit on Environment and Development (Rio de Janeiro 1992), the World Conference on Human Rights (Vienna 1993), the International Conference on Population and Development (Cairo 1994), and the World Summit for Social Development (Copenhagen 1995) also focused attention on both the unmet needs and the unique contributions of women to human development. The 1995 United Nations Fourth World Conference on Women, held in Beijing, made an international assessment of the status of women in relation to the goals set forth in the Nairobi document. The Platform for Action adopted in Beijing recognises two contradictory global trends affecting women – first, the growing strength of women's organisations and the women's movement, and second, the changing national and international economic, environmental and structural arrangements that are resulting in a negative effect on women the world over.

The International Conference on Population and Development (ICPD) of 1994 was the turning point in policy-making on women's health and development, particularly for women in the South. At the ICPD, the issue of decriminalising abortion and respecting women's reproductive rights received great media attention. Equally important was the issue of social, economic and political rights of women that were important to the women of the South, as was the 'development' agenda, the 'D' of ICPD. The development demanded by women of the South rejected the Western paradigm of economic growth; instead, it was based on a sustainable, equity-oriented model. Southern women's concept of development ensures meeting the basic needs of all and better living standards of the disadvantaged populations. This concept of development recognises that the health, well-being and security of people, especially the vulnerable (including women), depend on a fair distribution of resources and power — at home, in the workplace, in the community, in the country and the world. This development model promotes genuine people's participation, involving as many people as possible in decision-making about their lives. Equity-oriented development promotes social, economic and gender equity. Development policies that promote social justice and gender justice tend to be health-promotive.

Unfortunately, there has been a worsening of disparities in many countries as can be seen by the deterioration of human development indicators in successive Human Development Reports. The World Health Report 1995, *Bridging the Gap*, talks about worsening disparities both between and within countries. It also introduces a new category in its existing International Category of Diseases (ICDs) called Z59.5, which stands for 'extreme poverty'. It states that since there is an increase in extreme poverty, it follows that there would be an increase in the diseases of poverty. Women represent 70 per cent of the 1.3 billion people who live in poverty worldwide, and therefore bear a greater burden of disease (WHO 1995). The South Asian Human Development Report 2000 on gender clearly states that the existing gender discrimination in South Asia is amongst the worst in the world. The worsening of gender discrimination, increased violence against women and the 'feminisation of poverty' are highlighted in this report (Mahbub ul Haq, Human Development Centre, 2000).

Thus, while the international conferences and instruments have drawn attention to equity issues and more specifically, gender equity issues, international agencies like WHO and the World Bank have continued to develop their policies and programmes without ensuring that suit the needs of women in the developing countries (Qadeer Chapter 17 in this volume). In 1985, WHO incorporated maternal health into the broader category of Reproductive Health, which includes abortion, contraception, HIV-AIDS, reproductive tract infections and sterility services. However, according to Qadeer, 'For third world countries this expansion came at a time when even strategies for improved maternity care had not succeeded.'

The health packages promoted by the World Bank reflect the priorities based on Disability Adjusted Life Years (DALYs) calculations rather than on epidemiological priorities and principles of public health practice.

In Chapter 23, Ravindran discusses the role and contribution of feminists in influencing policy at the global level. She describes how feminists organised themselves to influence the agenda and outcome of international conferences since 1970s.

Global Economic Policies

With the end of the 'cold war' in 1990, most developing countries started to liberalise their economies and undertake structural reforms aiming at higher rates of growth. Globalisation gathered momentum with the World Trade Order (WTO) coming into force in 1995. Though it may be argued that globalisation is opening many windows of opportunity for millions of people around the world by fuelling economic growth, and that it has the potential to eradicate poverty, the risks for developing countries like India far outweigh the benefits. In India, economic reforms have exacerbated unequal gender relations, which influence not only household income distribution but also education of women and their access to primary health care and family planning services. The economic reforms have resulted in reduced expenditure on public provision for health, education and social services as well as shrinkage of food availability to poor families (Sharma, Chapter 27).

The Human Development Report 1999 clearly states that the international trade regimes have worsened disparities and technological gaps:

'Markets can go too far and squeeze the non-market activities so vital for human development. Fiscal squeezes are constraining the provision of social services. A time squeeze is reducing the supply and quality of caring labour. And an incentive squeeze is harming the environment. Globalisation is also increasing human insecurity as the spread of global crime, disease and financial volatility outpaces actions to tackle them.'

Market-oriented economic and trade policies and international trade regimes put further pressures on the poor, the vulnerable and women, as is shown by Swaminathan in Chapter 29. As quantitative restrictions on imports in concurrence with India's commitments to the WTO, the floodgates for cheaper imports open up and hurt local manufacturers. Thousands of small-scale industries are winding up and millions are losing their livelihoods. Women's suffering is increasing as casualisation of labour takes place. They suffer when they are denied minimum wages, equal wages for equal work, and their maternity benefits.

Swaminathan's case study, located in a rapidly industrialising district in South India, shows that situations where basic infrastructure is not in place, the combination of household chores and factory work, particularly for women workers, leads to tremendous stress, disease and ill health. Swaminathan argues that macro-level action in terms of investment in basic infrastructure and in making workplaces safe and disease-free needs to be undertaken alongside efforts to 'make *visible* the *nature* and *magnitude* of occupational hazards and diseases that workers in general, and women workers in particular, are prone to'. She emphasises women workers because the structure and organisation of households, workplaces, and institutions like trade unions and labour departments are so gender biased, that much of what women do, experience and suffer remains invisible and hence unaccounted, thereby adding to the marginalisation and devaluation of women's work and health status.

Agricultural Policies, Food and Hunger

Women's poor nutritional status has a lot to do with the double and triple burden they carry. The situation has been worsened by the globalisation process and international trade regimes, which treat food as a 'trade commodity' rather than a basic need essential for alleviating hunger and fulfilling nutritional needs. Changes in agriculture policies, where food production has been systematically marginalised to give priority to export-oriented cash crops and food processing, the winding down of the public distribution system (PDS) and the removal of food subsidies for the poor, have all made access to food difficult. Starvation deaths have taken place even while several thousand tonnes of food lies rotting in the Food Corporation of India's godowns.

In India, 70 per cent of livelihoods are linked to agriculture; any changes in agricultural policy, such as those associated with import liberalisation, would mean the wiping out of small farms and destitution of landless labourers who survive on the seasonal work provided by local agriculture. It is often forgotten that it is mostly women that work in the fields and are the real farmers. It is they who conserve seeds. With patenting of life forms (starting with micro-organisms), genes, cell lines, seeds and

medicinal plants by corporations, the implications for poor countries and poor through out the world are serious. Seed patenting makes saving, replanting and exchange of seeds illegal. Farmers, who have conserved the original seeds for centuries, become violators of patent laws.

Commercialisation of Health

It is women who have been the primary health care providers at home and have possessed knowledge of home remedies and folk medicines. Tribal communities have used indigenous knowledge and skills and indigenous plant resources for healing. *Neem*, turmeric, *phyllanthus niruri* used for jaundice, *karela*, *jamun* (for their anti-diabetic properties) and many other plant-based medicines have been part of the Indian knowledge system for centuries. Sadgopal reviews the various critiques of the Draft ISM (Indigenous Systems of Medicine) Policy of the Government of India in Chapter 22. She emphasises that the government would need to ensure that the health, food security and livelihood needs of rural communities get as much support from the ISM sector as research, production and export of herbal products. Patenting of these items will make all of us who use these for healing, violators of patent laws, as has been pointed out by the Shodhini collective in Chapter 14.

Health and healing have been seen as community services. Aggressive commercialisation and pharmaceuticalisation of health care has only made access to health care by the poor more difficult. Srinivasan and Shiva in Chapter 28 point to the effects of the new intellectual property rights relating to pharmaceuticals, especially in developing countries, and conclude that although patent protection of pharmaceutical products will be enhanced, this will affect poor countries adversely. They go on to say that it is likely that local production in developing countries will increasingly be replaced by imports of finished products.

Commercialisation of health has also resulted in unprecedented 'indebtedness', as medical care costs have spiralled and comprehensive health care has been replaced by 'curative care'. The WTO, especially, in the very writing of the Trade Related Intellectual Property Rights (TRIPs) agreement, has transferred medicines and drugs from the realm

of health to the realm of trade. When operationalised, the product patent laws will result in non-availability of drugs — as monopoly control under TRIPs will not allow production by other manufacturers even through different processes, as is possible at present under the process patent law.

Changing Policy Environment within India

Following the global trend, several new policies were formulated and programmes were launched in India. The CEDAW and the Child Rights Convention were ratified. Reproductive and Child Health (RCH) Programme was launched in fulfilment of India's commitment to ICPD. The RCH brought about a paradigm shift from the target-driven national family planning programme to a reproductive health approach. The Population Policy was announced in 2000 and a National Commission on Population was set up to monitor its implementation. The drafts of the National Health Policy 2001 and the Indian System of Medicine Policy are being discussed for finalisation; a National Drug Policy was announced in early 2002. In all these policies, there is a distinct trend towards privatisation and corporatisation. Das critiques the recent policies from a gender and rights perspective in Chapter 16. He points out that improvement in women's overall health status does not find place in the National Health Policy and the National Population Policy 2000. Concern for adverse sex ratio is also not uniformly expressed in the policy documents.

There is no denying that during the last decade, India has made substantial progress in the social sector. There has been a decrease in infant and maternal mortality rate, increase in life expectancy, eradication of small pox and the guinea worm. Population growth rate has experienced the sharpest decline (21.34 per cent) since independence. Literacy rates have increased significantly from 52.21 per cent in 1991 to 65.38 per cent in 2001. The gap in male-female literacy has come down from 28.84 to 21.70 (Census of India 2001). However, India still has one of the highest mortality rates and ranks a low 115 in the Human Development Index (UNDP 2001).

With the 93rd Constitutional Amendment, the right to education finally became a fundamental right in 2001, 11 years after the World Summit on Education for All in Jomtien. The Government of India declared 2001 as Women's Empowerment Year and released the National Policy for Empowerment of Women to ensure equal participation of women in India's socio-economic progress in the twenty-first century. The National Women's Policy was followed by the release of several state policies in quick succession. Chapters 24, 25 and 26 look at the state policies for women in Maharashtra, Andhra Pradesh and Chhattisgarh. A review of these policies reveals that while all three are seemingly progressive, they leave a lot to be desired. They are not well thought through and are inconsistent on several counts. While each talks of women's empowerment and rights, the preoccupation with demographic goals shows up in the mention of the state's population policy or the two-child norm. The litmus test of their commitment would be the budgetary provisions and financial allocations they make for women's programmes. On this count, too, they leave a lot to be desired.

Administrative and political changes were seen, despite political instability especially in the second half of the decade. The 73rd Constitutional Amendment brought in decentralisation and a bigger role for the *panchayati raj* institutions. The role of these institutions in the area of health is discussed in Chapter 33.

In Chapter 34, Vijayan reviews the decentralised planning process in Kerala with respect to the health sector. Five years into the process, she points out several limitations such as lack of reliable and correct data and inadequate resources like finance. She reports that active participation by local health personnel is lacking in the total health improvement of an area. Issues emerging from the globalisation process, like escalating prices of medicines and medical care, are also posing serious challenges.

Liberalisation of the economy and disinvestment has gathered momentum. The withdrawal of the state is stressed in all the newly announced and to be announced policy documents and development continues to be measured in terms of economic growth.

It must be recognised that policies and programmes designed to eliminate

poverty and to promote the economic well-being of all people will not succeed without attention to gender discrimination in economic arrangements: in the workplace, in the household and in the social and economic policies and programmes themselves. All national policies must be health promoting and should ensure gender equity and distributive justice. As Mahbub ul Haq puts it, 'Human development, if not engendered, is fatally endangered' (UNDP 1995).

About This Book

This volume of edited papers brings together papers presented at the National Consultation as well as some of the papers from the preparatory meeting held at Bangalore in October 1998. The preparatory meeting attempted to gather and prioritise grassroots concerns to be presented in the National Consultation. Representatives of groups working in remote areas of Bihar, the north-eastern states, Maharashtra, Gujarat, Uttar Pradesh and Tamil Nadu spoke about issues that affected women's health in their respective areas.

The volume is divided into two major sections. Section I consists of NGO experiences and perspectives and Section II analyses various policies from the standpoint of how they affect women's health. Each section is further sub-divided into areas of emphasis that offer insights for a fuller understanding of issues.

The first part of the section on *NGOs' Experiences and Perspectives* contains four chapters on organisations that have explored and implemented different ideas pertinent to women's health. In Chapter 2, the SEWA-Rural team describes the evolution of its women's health programme in the context of primary health care. The chapter explores the constraints and problems faced in developing a comprehensive women's health programme. In Chapter 3, Tara John analyses the experience of the Deenabandhu team with the primary health care model and focuses on their learning that the poor did not benefit from the hospital-based, professional-dependent, heavy input system that was being promoted. The Deenabandhu team progressed to a people-centred health system centred on Village Health Workers using herbal remedies

and promoting local practices. SEWA's experience of organising women around health is described in Chapter 4. The forms of organisation have ranged from *dais*' cooperatives and a health insurance programme to medical shops run by women members of SEWA. The last chapter in this section describes the processes through which men were involved in the women's health programme being implemented by SARTHI. The ten years' journey offers several valuable insights for SARTHI as well as other such programmes. Part 2 of Section I is on Training for Women's Health. The approaches towards training of programme coordinators by the WAH! network have been elaborated in the narration of experiences of the Southern, Western and Maharashtra WAH! programmes. The three sets of experiences highlight that phased-out training, complemented by orientation to the heads of organisations as well as support to individual participants in the intervening periods, increases the possibility of application of learnings from the training. Chapter 9 highlights the key principles learnt by SAHAYOG through a decade's work on training for women's health. Their experience indicates that women's health training has to be reflective and experience-based, inclusive of appropriate local practices, balanced in terms of inculcating gender-sensitive attitudes and enhancing requisite knowledge and skills. The SAHAYOG team emphasises that the trainer's role is very important indeed. The trainer has to be a role model for imparting certain values that underlie women's health, such as a commitment to gender equity, women's empowerment and social justice. And finally, Chapter 10 describes how the Women-Centred Health Project trained clinicians within a public sector health programme in gender-sensitive reproductive health. The unique feature of this training was the integration of clinical aspects with gender issues and communication and counselling principles. Part 3 of the first section on *NGOs' Experiences and Perspectives* contains three chapters on production of Educational Material for Women's Health. First, the CHETNA team describes the frameworks that it has evolved to review Information, Education and Communication material from a gender perspective. The latter part of the chapter elaborates the process for the development of gender-sensitive material. The Sama team raises some critical questions concerning the politics of IEC material production

and its use. This chapter focuses on how representatives of user groups can be involved to produce IEC material for their own use. Examples of culturally appropriate, locally produced IEC material are shared. The third chapter describes the processes initiated to encourage a woman-centred approach within the IEC Cell staff of a public health system. These processes resulted in the production of a broadsheet on reproductive tract infections (RTIs) with the participation of the field staff of the public health system. The importance of exploratory research on the perceptions of user groups, their beliefs and practices around RTIs, is highlighted through the experiences of the Women-Centred Health Project. The final part of Section I on *NGOs' Experiences and Perspectives* deals with Traditional Systems of Medicines (TSM) for Women's Health. Vd. Smita Bajpai discusses the work of Shodhini, a network of feminist researchers who documented the use of local herbal remedies for women's health problems. This documentation was followed up by an analysis based on ayurveda and phytology, which revealed the existence of a sound basis for the use of many of the documented herbal remedies. The rationale for incorporating local traditional remedies for women's health by women healers is strengthened when we consider the empowerment angle in terms of promotion of control by women over their own resources. And finally, in Chapter 15, the WAH! position on Traditional Systems of Medicines is elaborated by some Core Group members. They examine the health documents of the Government of India and indicate that TSM is a neglected area in the National Health Policy of 1983 as well as in the draft of the new National Health Policy (2001). Practical recommendations for policy change and programme strategies are laid out by the WAH! Core Group.

Section II focuses on the analysis of policies and programmes from a women's perspective. This section begins with an overview chapter by Abhijit Das in which he examines the current policy scenario in India. Das analyses the Draft National Health Policy, the National Population Policy and the National Policy for Empowerment of Women from the gender perspective. He then goes on to make several recommendations for mainstreaming gender into the Approach Paper for the Tenth Five Year Plan. After this overview chapter, Section II moves on to Part 5.

The six chapters of Part 5 are on National Health Policy and Programmes from a women's perspective. They include critiques of two policies. Shubhada Kanani examines the National Nutrition Policy through the gender lens, while Mira Sadgopal critiques the Draft Indian Systems of Medicine Policy. Sadgopal examines the critique of Jan Swasthya Sabha, Independent Commission on Health (ICHI) and the WAH! network to recommend, among other things, that traditional *dais* and local healers need to be recognised and given their rightful place in such a policy. She also mentions that the achievement goals of this policy need to be specified.

In Chapter 17, while analysing the Model Registration data, Qadeer emphasises that epidemiological and public health priorities point to the importance of dealing with the health problems of girls under 15 years of age, who bear a high load of mortality and who enter reproductive age with a disadvantage. She also underlines the importance of communicable diseases, which not only kill the young but remain the second major killer of women in the 15-45 years age group.

In Chapter 18, Nirmala Murthy examines the experience of implementation of the Reproductive and Child Health (RCH) programme. She discusses how administrative constraints and procedural bottlenecks hamper the smooth functioning of the programme, pointing out that these require systemic reforms. She also discusses the role of the private sector in RCH and emphasises the need for regulatory mechanisms and developing financial packages for the poor. Chapter 19 focuses on the health status of the girl child.

Part 5 ends with Chapter 23, in which Sundari Ravindran analyses the experiences of Brazil, Australia, Columbia and South Africa in developing women's health policies. She states that the policies of the four countries are based on women's health agendas that, despite their varying social contexts, have much in common. India can learn from the experiences of these four countries. The process of policy-making should be inclusive and involve women from the grassroots. Also, while being guided by women's perspectives is a good principle, it has to be balanced by just and ethical decisions about allocation of resources. Ravindran makes an important point that while having a women's health policy is desirable,

there is a need to mainstream gender concerns in all policies and programmes. This would be one way to ensure gender equity in health.

Part 6 is concerned with State Policies for Women. In this part, Lakshmi Lingam and Illina Sen review the State Women's Empowerment Policy for Maharashtra and Madhya Pradesh respectively, while Prakasamma looks at Andhra Pradesh's Women's Health Policy in Chapter 26. All these authors point out that while it is good that the state governments are developing women-related policies, many of the policies are flawed and inconsistent. Among other things, the policies do not identify ways in which their implementation will be monitored.

Part 7 contains six chapters dealing with other issues affecting women's health. In Chapter 27, Kumud Sharma discusses the effects of globalisation and economic reforms on women's health. She states that economic reforms are gender-biased as they ignore the unpaid work of women. Poor women are more vulnerable to health risks, inflation and uncertainties, which SAPs tend to increase. Srinivasan and Mira Shiva do a detailed analysis of the pharmaceutical industry and women's health in Chapter 28. They point out that while many drugs essential for women's health are not produced and marketed in adequate quantities, the industry promotes products of doubtful value like HRT (Hormone Replacement Therapy). They also point out that clinical research done by pharmaceutical companies leave out women completely.

In Chapter 29, Padmini Swaminathan examines the concept of work in the context of women and their health. She points out that while Central Statistical Organisation data provides official recognition of the considerable time that women spend on cooking, cleaning and child care, it does not capture the 'intensity of the effort extended on each of the tasks performed, and the overlapping nature of each of the activities'. She states that the issue of work intensity is extremely important as it has a direct bearing on well-being. Swaminathan examines the stress of women's work, both reproductive and productive, and relates this to women's health.

In Chapter 30, Bhargavi Davar carries further the discussion on mental health concerns of women. She examines how the women's movement,

as well as the discipline of psychiatry, treats women's mental health concerns. While the women's movement has been affirming in its stance, the institutional framework within which psychiatry operates is dehumanising and often violates the human rights of women patients. She proposes an agenda for the women's movement with respect to enforcing humane, ethical and gender-sensitive services in mental hospitals as well as for community mental health programmes. Davar also unravels some ethical dilemmas in the mental health work undertaken by women's organisations.

Khanna and Venkatachalam discuss violence against women as a health issue in Chapter 31. The authors establish that the magnitude of violence against women is of overwhelming proportions and has to be taken seriously by the health sector. This chapter also describes some state and NGO interventions in the area of violence against women.

In Chapter 32, Padma Seth discusses laws and acts related to women's lives and their health. There is an attempt to contextualise the legal dimensions related to women's health within the human rights framework and international instruments.

Part 8 of Section II includes two chapters on experiences with Decentralisation and Democratisation. Susheela Kaushik focuses on Women and Panchayati Raj institutions. She reviews the experiences of various states with respect to women in panchayats. She points out that there are several constraints which prevent women panchayat members from functioning effectively, a major one being lack of support by officials and male panchayat members. Women panchayat members also feel that adequate powers are not delegated to them; nor are there adequate support structures like domestic assistance, transport facilities and political information. Case studies of NGOs who have been providing support to elected representatives are also described. In Chapter 34, Vijayan reviews Kerala's experience of decentralised planning in relation to gender and health. She notes that although plan documents and handbooks make special mention of gender concerns, these do not seem to have percolated down to the local-level planning process. Among several other recommendations, she states that comprehensive studies need to be

undertaken to understand the specific women's health issues of the state, particularly of women belonging to marginalised groups like the dalits or fishing communities.

The last part of the book, Part 9, is on Mainstreaming Gender. In Chapter 35, Thelma Narayan discusses the gender and power issues in medical education. She states that a review of Medical Council of India recommendations on Graduate Medical Education sadly lacks in gender sensitivity. Not just the contents of medical education, but also the methods need to incorporate a gender perspective. Narayan also discusses values in medical education and highlights the issue of sexual harassment in the medical profession. In Chapter 36, Renu Khanna and colleagues describe the ways in which the Women-Centred Health Project tried to mainstream gender within the Bombay Municipal Corporation's public health department. The learnings from this experiment are extremely important for the public health system. And finally, Chapter 37 outlines CHETNA's experience in mainstreaming gender.

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Section II

NGOs' Experiences and Perspectives



Part 1

Some Models



Chapter 2

Women's Health Programme in the Context of Primary Health Care SEWA-Rural Experience

SEWA-Rural Team

SEWA-Rural is a voluntary development organisation involved in rural health and development work in Bharuch district, Gujarat, India, since 1980. The area covered by the project has a predominantly tribal population, with an agriculture-based economy. However, almost two-thirds of the population are landless labourers. Only 60 per cent of males and 40 per cent of females are literaté. The major health activities of SEWA-Rural include a general community-based hospital at Jhagadia, a comprehensive Community Health Project (including a Primary Health Centre [PHC] and Integrated Child Development Scheme [ICDS]) covering a population of about 40,000 in 30 villages, training and research in community health, and a comprehensive outreach eye care programme in 250 villages of two blocks (population: 250,000).

Here, we focus on programmes and activities related to women. During the first decade, due to several reasons, more emphasis was placed on mothers and children. The main objective was to reduce the burden of morbidity and mortality among them. Gradually, other aspects of women's health were taken up – such as reduction of the burden of unwanted

childbirth, generation of awareness about reproductive health among youngsters, treatment of Reproductive Tract Infections (RTIs) and childless couples, etc.

The Approach

The basic approach of the organisation centres around providing an integrated package of health services to meet the multiple and varied needs of the people at their doorstep. We have tried to make the services convergent at the user as well as at the provider level, making them easy to deliver, more acceptable and, at the same time, cost-effective and affordable. The focus is on individual and family needs rather than on projecting numbers. We have also tried to encourage the participation of people in the programme, keeping in mind their social, cultural and economic perspectives. Along with delivering quality care, care has been taken to educate the community and make them aware of the basic concepts of health.

In addition, an attempt has been made to involve male members of the family/community in the programme. The measures adopted to do this include taking them into confidence at every stage, i.e., from conceptualisation of the programme, to decision-making, to an acceptance of services. It is hoped that with this strategy, apart from allowing and supporting their wives to adopt services of their choice, the men themselves will come forward to accept and practise contraceptive methods and eventually live responsible sexual and reproductive lives.

Package of Services Offered

Maternal Care to Promote Safe Motherhood

Initially (1984), the major focus was on maternal care services with more emphasis on antenatal care along with strengthening of *dais* or Traditional Birth Attendants (TBAs). Repeated training sessions at regular intervals were organised for TBAs. These were supplemented by intensive education and motivation of women to utilise antenatal care services at the village level, and to ensure that normal delivery at home was conducted

by a trained *dai*, using the aseptic delivery pack distributed to mothers by SEWA Rural fieldworkers.

After five years of work, the number of women utilising the services went up significantly. Despite this, mothers continued to die in roughly equal numbers year after year. We started identifying mothers at high risk of dying, persuading them to take enough care to prevent death. Many women suffering from severe anaemia could not be saved simply because they or their families were unresponsive to our motivational or educational efforts. Using various methodologies, we checked on the compliance of pregnant women in taking iron tablets, and came up with differing results. We therefore decided to further strengthen our educational and motivational efforts. Since the project area had a high level of hookworm infestation, we introduced de-worming as a routine measure. The incidence of malaria was also very high. To counter this, we introduced a weekly dose of chloroquine prophylaxis, first for the primis, and later for all pregnant women, to be taken throughout the year.

During the course of our work we realised that many of the elements of conventional antenatal care have limited value and the greatest and most predictable risk factor for maternal death is pregnancy itself. Most risk-screening programmes succeed in netting only a small proportion of women who actually develop life-threatening complications. Once these complications develop, only timely hospital care can avert death. The antenatal care package was thus trimmed to become more effective, its main thrust being the preparation of the mother and her family for childbirth, the early identification of complications, and access to hospitals as soon as complications are identified. In addition, the TBAs were trained, if not to deal with complications, at least to avoid doing further damage (Table 2.1).

In 1991, when there was a sudden spurt in maternal deaths, we discovered that most of the excess deaths could be accounted for by unwed mothers undergoing secretively induced 'criminal' abortions. Although it is fairly unlikely that such deaths could have escaped our notice in previous years, we felt it advisable for health-workers to keep a vigil on unwed pregnancies. The policies at the hospital with regard to performing

Table 2.1
Maternal Care

Parameters	82-83	84-85	89-90	94-95	97-98
Quality of antenatal care	4%	11%	58%	65%	61%
PN care	1%	58%	74%	95%	82%
Home delivery by trained <i>dais</i>	—	80%	90%	86%	74%
Hospital delivery	10%	7.75%	16%	32.5%	36.5%
High risk referral	-	<10%	33%	65%	81%
MMR	12	6.2	6.7	4.6	1.1
Hb estimation	<4%	<10%	57%	95%	94%
Hb less than 4%	-	-	-	7.9%	1.0%

abortions (MTP) were also liberalised and made more user-friendly. For reasons we do not fully understand, there have been no further deaths among unwed mothers, although unwed pregnancies continue to occur at a fair rate. Very few unwed mothers come to us for termination.

Prevention and Management of Unwanted Pregnancy

It was commonly observed that many young girls and women become pregnant when they are not ready for childbirth. After several brainstorming sessions, user-friendly services to terminate unwanted pregnancy were introduced at the base hospital. About 70 women in the project villages (40,000 population) undergo medical termination of pregnancy every year. It is encouraging to note that more women, and particularly young, unmarried girls, are now accepting MTP rather than going to quacks. Husbands often accompany their wives to the hospital where the couple is motivated to accept any contraceptive method of their choice after MTP. Couples with only one or two children rarely opt for MTP just because they want to ensure enough spacing between children. They usually opt for Copper -T insertion or any other spacing method that suits them. Many of the women who come in for MTP, but who already have the desired number of children, opt for simultaneous tubectomy.

Programme for Newly Married

Introduced in 1995, the main thrust of this programme was to prevent unwanted and early pregnancy. About 300 marriages take place every year in the project villages. It was decided that health-workers should try and build a rapport with these newly wed couples and follow up on each of them as soon as the marriage ceremonies are over.

The majority of marriages in the villages occur at a relatively young ages. Young, newlywed couples have very little basic knowledge but many misconceptions about various aspects of reproduction and sexuality, including anatomy and physiology, safe period, fertilisation, contraception, etc. To become pregnant very early after marriage is considered very important — particularly by in-laws. The newly wed couple is thus under great pressure to comply. That this belief is widely prevalent all over India can be seen from the fact that there is hardly any difference in the length of interval between the date of marriage and the coming of the first-born among the better educated and the uneducated. Efforts were therefore initiated to provide proper attention to newly weds during the initial period after marriage.

User-friendly Family Planning Programme

SEWA-Rural has adopted a client satisfaction approach wherein the status and needs of each individual on the list of eligible couples are duly considered and acknowledged. Instead of viewing all eligible but unprotected couples as one homogeneous group, they are segmented according to their current fertility status, age, the sex composition of their living children and their preference for specific methods of family planning. This exercise helps us in determining the ideal contraceptive method for the respective couples. The service provider discusses the advantages and side effects of different methods with each couple in order to promote the use of contraceptives. Such an approach helps service providers to better understand the needs and preferences of clients whom they seek to serve and, in the process, raise the level of satisfaction among couples.

Based on what the couples choose, a village-wise list is jointly prepared by a team of male and female village-level health-workers at the beginning

of the year. Even a couple's desire to go in for another pregnancy for whatever reason, is duly respected and acknowledged. The health-worker's task is to encourage and facilitate only those couples who have expressed the desire and willingness to accept a contraceptive method of their choice at an appropriate time of the year. This becomes the working target for the sub-centre team. Since the target for each village is evolved by the teams themselves and not forced upon them, there is no pressure on individual team members to achieve any set number. The entire exercise is the joint responsibility of the team. In addition, there is no pressure on couples in the project villages to only accept services offered by the SEWA-Rural programme; they are free to seek family planning services from any source of their choice.

When a couple does come forward to accept any of the family planning services offered by SEWA-Rural, proper selection, screening and counselling of beneficiaries are given due importance. Special care is taken to ensure that the children, particularly the youngest, are appropriately healthy before the woman is allowed to go in for sterilisation. All these services are given round the year on a regular, weekly basis, thereby eliminating the congestion and chaos characteristic of the camp approach. Proper follow-up by the health-workers immediately after sterilisation or Copper-T insertion and ensuring referral whenever required are also given due importance. A postcard/note is given to each woman undergoing sterilisation, outlining the post-operative care she needs to take after going home. The husband and other family members are also made aware of this and we are happy to note that after the operation, most of the women now get enough rest, attention and care at home. Though small, all these measures have convinced the community that SEWA-Rural is not playing a numbers game but has a genuine interest in the welfare of the community.

Infertility Clinic

SEWA-Rural also counsels and treats couples suffering from infertility, including making arrangements for recanalisation in the case of couples who have unfortunately lost their children after accepting permanent methods. In this, SEWA-Rural was fortunate enough to acquire the

services of an expert and senior gynaecologist for its infertility clinic.

There are about 125 infertile couples in the project villages. Most of them (about 65 per cent) suffer from primary sterility. Health-workers are trained to counsell the couples and encourage them to follow appropriate sexual practices. Since most of the couples prefer to go to quacks or *bhagats* and *bhuas*, they are specifically motivated to avail the services of qualified medical professionals with expertise in managing infertility, either at SEWA-Rural or other private clinics. Though women are still blamed for the lack of a child, more and more men are now willing to accompany their wives and undergo repeated medical examinations and necessary treatment.

Adolescent Programme

Adolescent children are generally a receptive and enthusiastic lot. Though young, they are old enough to comprehend issues related to their future responsibilities. SEWA-Rural's effort is to prepare them for responsible parenthood and citizenship. We have observed that it is during adolescence that most children get involved in different practices related to reproduction and sexuality. Their curiosity, unsupported by basic scientific knowledge about these aspects, makes them vulnerable to unhealthy influences that often have long-term consequences.

In the project villages, very few in the adolescent age group continue with their schooling. Many of them are school dropouts, involved in some type of labour for income generation, with girls additionally supporting household work. There has been substantial increase in premarital sexual activity among adolescent youth and it is as high as 80 per cent among adolescent boys and 60 per cent among girls.

We have experimented with a few groups of boys and girls, both school-going and dropouts, educating them on issues like sexuality and reproduction. Their response has been quite encouraging. The need is to build rapport and confidence among teachers, parents and the community at large for taking up such issues with adolescent groups. In a suitably unthreatening and encouraging environment, these children are able to share their feelings and experiences without too many inhibitions. They

are also more open to new insights. Boys, particularly, have evinced keen interest to learn and understand more about these issues.

Management of Reproductive Tract Infections (RTIs)

In 1988-89, we conducted a study in our project villages to understand the perception and pattern of illnesses suffered by women during their reproductive lives. The study revealed a high incidence of RTIs, with 84 per cent of women having one complaint or another and 42 per cent showing definite signs of ill health on clinical examination.

In the beginning (since 1980), treatment for women's gynaecological problems was provided at the hospital. However, a community-level programme involving multipurpose female health-workers was begun in 1995 by providing them with additional training and inputs. Thus, detection and treatment of RTIs through the syndromic approach was made available at the village level as part of the pilot study. Identification of women suffering from RTIs, case histories, examination, diagnosis, treatment and referral were the main components of the intervention. However, tracing the woman's partner and persuading the women to overcome their reluctance to undergo a gynaecological examination are problems that we have yet to resolve.

Achievements

As described in the preceding paragraphs, a number of innovations were introduced in the SEWA-Rural programme to improve the health status of women. As the quality and coverage of health services began to improve, their impact was obvious on many of the health indicators and vital statistics. Thus, most of the goals and targets under Health for All by 2000, as envisaged by the Indian government, were more or less achieved within five years of our project work. The infant mortality rate (IMR) and childhood mortality rate (CMR) were reduced by 50 per cent. Utilisation of maternal health services has already reached the expected level. More and more women are coming forward for regular check-ups and investigations. More number of mothers, especially those in the high-risk category, have started using the referral services provided

by the hospital. The maternal mortality ratio, which was over 1,500 when we began the project, has come down to 110 in last 15 years. The key indicators are shown in Table 2.2.

Table 2.2 Changes in Key Indicators Related to Women's Health				
Parameters	1982-84 (Baseline)	1989-90	1995-96	1998-99
Antenatal care	<25 %	80.5 %	76 %	84 %
Maternal mortality ratio	>1500	670	460	110
Couple protection rate	37	62	69.5	69.6
Crude birth rate	35.6	27	22	20.2
Sex ratio	919	-	958	982
Average no. of children at Sterilisation	-	3.1	2.9	2.8
Infant mortality rate	172	87.6	69.4	46.6

Over the years, SEWA-Rural's programmes have also made other significant impacts on the situation of women. Anaemia in pregnancy is slowly coming down. Ninety per cent of families are readily purchasing the delivery pack sold at a subsidised rate. Sixty-five per cent are responding to the postcards sent to them for appropriate action. Most of the newly married couples are eager and interested to learn more about matters like sexuality, fertilisation, menstruation, safe period, contraception, etc. Fifty per cent of the young newly weds are accepting services like Tetanus Toxoid injections, tests for haemoglobin and blood group, measurement of blood pressure, and Iron-Folic Acid tablets. Half the number of couples have tried at least one contraceptive method. However, most of them have been unable to continue with it for several reasons. While many of them do realise the importance of delaying their first pregnancy, they invariably succumb to the deep-rooted family and social pressure to become pregnant at the earliest. More infertile couples are coming in for professional medical treatment. So far, of the 125 infertile couples identified, 69 have sought treatment at the hospital and eight

have already conceived after proper investigation and treatment. An increasing number of husbands and family members now understand that they were wrong in blaming the women for not having a baby. About 70 women undergo MTP every year. More and more young, unmarried, pregnant girls are coming for MTP to the hospital rather than going to quacks. More couples are accepting different contraceptive methods after MTP; those already having the desired number of children are opting for simultaneous tubectomy. The couple protection rate has gone up to 68.4 per cent and the birth rate has come down to 20. The average number of children and mean age of women at sterilisation are also going down.

The sex ratio has gradually gone up from 919 to 982 and female mortality in the reproductive age group has gone down from 30 per cent to 19 per cent in last 15 years. In 1984-85, 68 percent of the women were dead by the age of 45. This figure has reduced to 42 per cent at present. A greater proportion of women's morbidity is coming to light. Women are gradually becoming more aware and bold enough to voice their problems and seek health care.

While some of the changes can be appreciated from the figures just described, many vital aspects are better understood in qualitative terms. A number of studies have been conducted to understand and document the results of such interventions (see References for published and unpublished papers). Men are slowly beginning to recognise the importance of their pregnant wives' health. About 40 percent of them seek out health-workers both to get their wives registered early and for subsequent antenatal care. One of every three men has started accompanying his wife for her check-up at the hospital. Many of them now choose to remain present during their wives' delivery and actively participate in making arrangements for vehicle and other support whenever necessary.

Though the data and achievements appear impressive, it should be noted that these are in-service data (while providing services to disadvantaged sections) and may not stand up to the rigours of research requirements. Secondly, since the size of population is small, impact-related data, such as that related to maternal mortality, should be judged accordingly.

Limitations

Because women's health issues were addressed while working within the system of primary health care that covers almost all aspects of community health, SEWA-Rural experienced the following constraints

1. Lack of adequate human resources, materials and infrastructure to cover all components of primary health care, in addition to the ongoing curative work at the hospital.
2. Although a variety of interventions for reproductive health were introduced, the evolution of a comprehensive model could not be adequately achieved. Several components that could constitute the model were developed in varying depths; for example, in adolescent health, we have only just begun explorations of sexual behaviour, awareness and education about human body, conception, contraception, nutrition, etc., while taking care of unwed mothers. While to an extent we did address the problems of married adolescents through the newly married couples' programme, we did not reach the stage where all these components could be integrated into one comprehensive programme. However, we believe that it is only a matter of time before this is achieved.
3. Mobilising, motivating and involving women as well as the larger community in health care, particularly in its preventive aspects. Health does not seem to be a priority, especially among the socially and economically weaker sections of community.

Lessons Learnt

Some lessons that we have learnt in the course of our two decades of work are:

1. It is possible to adapt the PHC outreach programme model to cover a large number of reproductive health services. These will, however, need a larger resource allocation; the existing PHC staff and resources are rather insufficient to support even the current programmes. Change in the mind-set of health functionaries and

political will are required at all levels.

2. When, in a given community, the proportion of maternal and neonatal deaths or morbidity is not very high, it is extremely difficult to effectively educate the community to take action, and to train health-workers to identify and effectively tackle such events.
3. As expected, 'service delivery' is far easier than bringing about changes in the behaviour pattern of a community. The dynamics of behavioural change and sustenance of such change are not easy to predict. It is particularly important to understand this in the context of the larger environment, where 'fashions' change every five years.
4. Community health research, even operational research, requires large amounts of time and effort. It is very difficult to sustain it along with health services, since the services quickly gain priority. A way out could be to have permanent and committed senior staff (in addition to more staff at junior levels), but this may be easier said than done in rural areas. It may be difficult to carve out control areas in service organisations.
5. Training programmes are an effective way of dissemination and sharing of experiences. Both services and research provide rich material for training, and the process of training and interactions with trainees are also sources of ideas for services and research.
6. The importance of PHCs as an area where meaningful research may be possible cannot be overemphasised.
7. Hospital support is very important for research/community health work/training. Referral services make it possible to cross-audit the quality of care provided by the outreach service programme as well as by the hospital. However, this would require regular and frequent coordination and communication channels.
8. Attitudinal change in workers is as important as change in the system itself.
9. Upscaling, even locally, has its own dynamics and problems. Similarly, decentralisation of responsibilities and powers, though

desirable and laudable, is not easy and is often a time-consuming process.

10. At the village level, women's groups/*mahila mandals*/Gram Panchayats can take up specific responsibilities if they are given some decision-making powers. For instance, they can handle such activities as target setting, selection of village health-worker, education and awareness work, identification of women and children under high risk, monitoring of some of the activities, disbursement of honorarium to the village worker, provision of support to a family as and when needed, etc.
11. There is a need to have a small, permanent place like a health post or *mahila kutir* where activities like running a dispensary/running an *anganwadi* centre for preschool children/overseeing deliveries/maintaining a meeting venue for women/conducting health check-ups/running a medicine-contraceptive depot, etc., can be carried out.
12. There are limits to community participation in a given programme, more so in preventive health care. Health is not yet a felt need among socially and economically deprived populations.
13. There is the larger problem of field-testing interventions: Who will do it? The government? The voluntary sector? It is necessary to determine its feasibility and other related issues.
14. Mental health, which has so far not been addressed, is emerging as a major issue.
15. Unlike other areas, in some tribal areas, men's health is no better than the women's and addressing only women's health in isolation will not be sufficient in the long term.

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Chapter 3

Comprehensive Women's Health Programme as Part of Primary Health Care The Deenabandu Experience

Tara John

September 1978 saw the formulation of the Alma Ata declaration of Health for All by the year 2000. On the basis of experiences from numerous countries, the conference affirmed that Primary Health Care (PHC) was an '*integral part of social development in the spirit of social justice*'. Through this approach, the proponents of PHC hoped to address existent health problems of communities by providing promotive, preventive, curative and rehabilitative services while also feeding into the overall economic and social development of the community and the country at large. Justice and equity were some of the key issues to be addressed.

The PHC agenda was based on two implicit assumptions (LaFond 1995:23)

1. The world economy would continue to grow as in the 1960s and 1970s.
2. The volume of external support for PHC would continue, if not increase, to enable developing countries in the transition to PHC.

Neither of these assumptions materialised (Abel Smith 1986: 202-13). Recession, debt, the oil crisis and declining terms of trade in the early part of the decade devastated the economies of several countries and greatly influenced their public sector spending. Moreover, aid from industrialised countries was drastically reduced. According to the United Nations Children's Fund (UNICEF), total aid funds allocated to health, nutrition and family planning fell from 7.5 per cent in 1979 to 5 per cent in 1987. Self-reliance and sustainability, which were two explicit components of PHC, were thus in jeopardy.

The Deenabandu team believes that the essence of PHC was lost in its implementation because its foundation did not rest on the knowledge and experiences of the people it was aimed at. While talking in terms of simplicity, relevance, appropriateness and cost-effectiveness, PHC largely evolved into an expensive system that needed large, external inputs. One of the main contributing factors has been the overdependency of the PHC on a Western medical system of health care that relies on expensive trained personnel, drugs and infrastructure. Although the declaration does acknowledge a role for traditional medical practitioners in the system, it underplays their importance and relevance. The declaration states that, 'With the support of the formal health system, these indigenous practitioners can become important allies in organising efforts to improve the health of the community' (WHO 1978:63). It takes for granted that the allopathic system is the formal one and the other informal and therefore somehow less scientific, thereby needing the backing of an established system, i.e., the allopathic. The issue, therefore, is not one of just semantics but of ideology, where one system of medicine exerts hegemonic control over others.

Based on its experiences, Deenabandu believes that PHC can be made sustainable if it is based on local knowledge and health skills, drawing upon the allopathic system of medicine only when and if necessary. Its strength and relevance to the poor would lie in its ability to use and build on their vast, experiential health knowledge – knowledge that has developed over generations in conjunction with their environment.

The PHC process would thus be an empowering process, particularly in

relation to women who are the main instruments of health maintenance at the village level. '*Power*' would be people's ability to use their knowledge to transform themselves and society. This power, when harnessed on a wide scale, could be used to transform large areas — in this case, a particular locale. The women who are part of the Deenabandu network have been able to mobilise their communities on the basis of health, but have politicised the whole issue by defining health as a state of social, political and economic well being.

The Deenabandu Experience

Women in Development Trust (WID), Deenabandupuram, has its origins in a health programme of Christian and Gandhian inspiration, which was started in 1946 in the Chittoor District of Andhra Pradesh. The Trust was registered as a separate organisation only in 1987. Drs. Hari and Prem John, founders of WID, are both medical graduates of the Christian Medical College at Vellore in Tamil Nadu and they first joined the programme in 1969. In 1971, they built a fully equipped 40-bed hospital that became known for its excellence in curative care. At that time, it was the only place within a radius of about 60 kilometres that offered such care. The period 1969-73 saw extensive curative services offered at the centre, coupled with a mobile clinic that took allopathic medicine into the villages. However, as Dr. Prem John has himself admitted, 'Our sophisticated medical education also taught us to look down upon anything indigenous, and an over-reliance on technology handicapped us in village conditions' (John and John 1984:2).

The general belief during this period was that outside inputs based on technology, packaged as a time-bound and measurable programme and staffed by professionals, could change the ill health patterns in communities. Lack of training in the social sciences kept the husband and wife team in ignorance of the complex interactions between various forces within the community. '(We were) totally unaware of the true socio-political situation in the country, and we were unable to see the true cause of ill health in communities, which is poverty' (ibid.). Their education had not prepared them to face the realities of rural India. The doctors

functioned on certain strong assumptions:

- That health programmes per se could bring about good health, forgetting the crucial role that various social, economic and political factors play in the everyday life of the poor.
- That lack of schooling also meant that communities possessed no native knowledge or skills, thereby sidelining valuable indigenous help in building the programme.
- That most of the problems of the poor were due to overpopulation and therefore implemented an extensive family planning programme without recognising that overpopulation is only a symptom of a deeper social malady.

In the words of Dr. Hari John, 'Overcoming such assumptions was made tough by the deficiencies in our training and our initial inability to transcend class values' (ibid.). Forty per cent of the population covered by the organisation were dalits. Almost 50 per cent of them were landless while most of the others possessed non-arable land (John and John 1994:16). The infant mortality rate (IMR) from 1969-73 remained almost unchanged at 127/1000 live births. The benefits accruing from the hospital, mobile clinics and other forms of curative care were confined to the rich, upper caste people who could afford the hi-tech services offered. When these realities dawned on the team, they began a personal and professional evolution that would radically affect the programme. One of the first changes was the decision to work only with the most oppressed section of society, namely dalits, and among them, particularly women.

Right from the start, one of the primary considerations of the organisation had been cost. The team felt that the use of doctors would increase the cost of health care by almost two-thirds. A rather humbling realisation was that of the 34 illnesses most common in the communities, 30 could be prevented simply through health education or health education in combination with simple technology like vaccinations or early diagnosis and treatment with appropriate and readily available remedies (ibid.). It was also during this period that the team made another important discovery. They found that each village community had its own informal health care system. This system, which was the first line of health care

that rural people accessed, rested in the hands of local midwives, mothers and traditional healers. The system was used not because it was valid but because it was accessible, affordable and in the hands of people who were familiar with the patients. Also, since most of the traditional practitioners were women, other women found it easier to relate their health problems to them without shyness or hesitancy.

Such discoveries helped the organisation in developing the idea of using female Village Health Workers (VHWs). The plan was aimed at bringing health care not only back to non-professionals like VHWs but back to individual families where it originally rested before the advent of Western medicine in India. At this point, the doctors and nurses had to start forgetting a lot of what they knew and start learning anew, except that this time around they were learning from the community and building on what the community knew. The Deenabandu team thus gave importance to people's knowledge while also enhancing existing knowledge. And while the VHWs were paid for their services by their patients, they did not insist on such payment as they were receiving a stipend from Deenabandu for their work. Nevertheless, everybody who benefited by their services gladly paid in cash or kind.

Although the VHWs had been chosen by 1975, health education in the villages was still carried out by auxiliary nurse midwives (ANMs). Through 1978, the VHWs acted mainly in support of the programme's curative services as offered by the hospital and mobile clinics. Mobile clinics were held regularly until the team realised that they were hindering the community's acceptance of the VHWs and decided to stop. Thus, it was only in the late 1970s and early 1980s that the VHWs really began expanding their role. By 1981 they were handling 60-80 per cent of the curative work. At that time they were using a select range of Western medicines that were provided by the organisation at a nominal price. By 1984 they had switched to local practices and herbal remedies, with the occasional exception of aspirin for fever. Vital statistics like the IMR, birth rate, death rate, maternal mortality rate and malnutrition rates, all showed steady and sometimes spectacular decline from 1973 onwards. The IMR declined from 127/1000 to well below 50/1000 in 1984, incidences of second- and third-degree malnutrition were not seen any

more, while first-degree malnutrition also showed a healthy decline (John and John 1985:4).

Celebrating Vulnerability

When the women first started training with WID, they actually believed that they did not know anything. The oppressive nature of gender relations ensured that women's knowledge was excluded from the general definition of what constituted knowledge. Even though a traditional birth attendant was respected for her skills, an average rural woman who also had a collection of herbal and home remedies in her repertoire of knowledge was refused acknowledgement. It was only through a gradual process of unravelling information, building confidence and further enhancing their information base that the women finally realised that they indeed had valuable knowledge. This was an important breakthrough for the programme.

This realisation of their knowledge made the women understand the power they could wield within a community. Their self-worth increased and their newborn confidence gave them courage to transform themselves in a manner and to an extent that the men could not. Women's *sangams* were formed and micro-credit schemes served to increase their disposable income. 'A new militancy has crept in among women, changing their dealing with government officials and their own menfolk' (John and John 1984:4). Due to the catalytic influence of the VHWs and their efforts at building awareness within communities, supported by collective bargaining, primary income through wages also rose to the recommended national levels.

Most women play triple roles – the reproductive (childbearing and rearing), the productive (as secondary but most often primary wage earners), and that of community management. It is argued that women, within their gender-ascribed role of wives and mothers, struggle to also manage their neighbourhood. 'In performing this third role they implicitly accept the sexual division of labour and the nature of their gender subordination' (Moser 1989:1801). Women who actively participate in

community activities are often successful and this lends them added confidence and stature. Despite the fact that such participation invariably translates into further burdening their already burdened lives, the women enjoy the visibility and recognition it affords them. Their participation in community activities has also helped in bringing about a metamorphosis in the psyche of the rural male, leading to a reversal of roles within the home. Very often, when the women are caught up in community management work, their spouses take on the household chores. These are the same men who at one time used to physically abuse them, prohibit them from joining *sangams*, and sneer at them along with the rest of the community. Such changes not only impact certain individuals but the entire community.

Further, the experience of the women in Deenabandu clearly contradicts another argument that community management work is not recognised for it is seen as 'natural' and 'non-productive' and therefore not valued. Every single VHW would disagree with this statement, as it has been community management work that has earned them economic independence along with status, respect and recognition, not only from their own village community but from neighbouring village communities as well.

The Deenabandu team did not consciously build gender into its planning process. Although their concern had been health, their approach encouraged illiterate, physically abused and oppressed dalit women. Despite the absence of a clearly formulated plan, '*strategic gender needs*'¹ were given priority. At the same time, '*practical gender needs*'² were also taken care of. The Deenabandu team politicised health, thereby successfully converting a practical gender need into a strategic gender need. Traditional health skills, despite the sexual division of labour, have contributed positively to the reversal of women's roles and status within the family and community.

There is an understanding that 'PHC without a referral system is doomed to failure' (WCC 1993:4). In the area covered by Deenabandu, when health problems are not dealt with in the early stages and a particular health situation gets complicated, people do access doctors and hospitals

in the nearby town of Chittoor. This does not imply that PHC is redundant in the villages; rather, it indicates that allopathic medicine also plays a role in the PHC system, albeit a minor one. It is necessary only as a measure of last resort. In the long run, it is only people's knowledge, rather than external interventions like hospitals, doctors and drugs, that can deal with their problems in a sustained manner.

The Deenabandu experience indicates that enhancing traditional skills can lead to the enhancement of the capacities of women as well as their communities. As the self-confidence and self-worth of the women increased, they were able to transform not only their own lives but also that of their community. This transformation happened around issues that the women themselves felt are important to their lives. While the Deenabandu experience is very context-specific, it nevertheless offers us several lessons, especially in terms of respecting indigenous knowledge and the advantages of focusing on the most oppressed section of society, namely, women.

In retrospect, the trial and error method followed by the Johns might perhaps hinder replication of programmes such as theirs. However, every problem is different and so are the complex realities within communities. As the Johns say, 'The answers are always different; there are similar processes perhaps, but there is no direct transfer of experiences.'

Notes

1. Strategic gender interests which translate into strategic gender needs are 'those which are formulated from the analysis of women's subordination to men for more equal and satisfactory organisation of society than that which exists at present, in terms of both structure and nature of relationships between men and women (Moser 1988:1803).
2. Practical interests which would translate into practical needs do not generally entail a strategic goal such as women's emancipation or gender equality, nor do they challenge the prevailing forms of subordination even though they arise directly out of them' (Molyneux 1985:233).

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*Chapter 4***Organising Poor Women for Health**
Learnings from SEWA

Mirai Chatterjee

SEWA has been organising poor, self-employed women for full employment and self-reliance for over two decades. Though our focus is on helping women achieve self-reliance, during the course of our work we observed several problems concerning poor women's health that were impeding this objective.

Women often say: 'Our health is our only wealth'; or 'As long as we are healthy we can work. And as long as we get work we survive.' SEWA Bank's experience and data reveal that the mortality and morbidity of a woman and/or her family members is the primary cause for stress in her life. It is a major reason for defaulting on loan repayment and for indebtedness. When, in 1977, SEWA Bank reviewed the loan performance of its depositors, it found that 500 women were defaulters. The major factor affecting non-repayment was the ill health of the borrower, leading to inability to work and earn and hence inability to repay the loan. Of these 500 women, 20 had died – predominantly during childbirth.

Another concern that is uppermost in women's minds is the escalating

cost of health care. Our members routinely spend between Rs. 500 and Rs. 800 per year on health-related expenditure. This steep escalation can in part be explained by the rapidly increasing costs of drugs themselves. The cost of the life-saving anti-TB drug Rifampicin, for example, went up three times in one year (1996) alone.

Our work in the field revealed that:

- Women in the informal sector do work that is physically demanding, and often involves harmful substances. They also work long hours in positions that negatively impact various parts of their body. Pregnant and feeding mothers frequently work in circumstances that lead to miscarriage or affect the health of the child. *Occupational health* is thus a major issue for poor women.
- Women's health affects their work. Work in the informal sector is mainly manual, and productivity depends on a body in peak physical condition. Unfortunately, because of poor nutrition, lack of care during pregnancy and childbirth, living in unsanitary conditions and lack of access to health care, most women have poor physical (and often mental) health. This causes a fall in productivity and income, culminating in a vicious cycle of deteriorating health and increasing poverty. Access to *social security* is therefore essential for poor women.

These findings forced us to initiate programmes for maternity benefits, safe childbirth and health in general. SEWA developed its health team with the following basic approach:

- All health services/care should be needs-based and demand driven.
- All health care should strengthen women's quest for full employment and self-reliance (SEWA's goals).
- A community health/primary health care approach should be holistic and integrated both within the health sector and with other economic activities.
- Women should be made the primary health care providers; they should be given the necessary inputs and training for this.

• All health services should be provided in a way that would contribute to long-term self-reliance (both cash and in-kind contributions from women should be encouraged).

- Initial curative care should be slowly augmented by health education, with special emphasis on the latter.
- Strong referral care should be provided through coordination and collaboration with both government and pro-poor, affordable, private health care institutions.
- Rational, generic drug therapy should be used.
- Grassroots action should be combined with policy action at state, national and international levels for more pro-women, pro-poor health policies and resource allocations.

Some examples of health action initiatives undertaken by SEWA are:

1. Local women (from villages and poor urban neighbourhoods), often *dais*, were organised to serve as 'barefoot doctors' for their own communities. These women then formed their own health-worker and *dai* cooperatives with SEWA's support. Four such cooperatives are active at present. In an additional two drought-prone districts (Banaskantha and Surendranagar), *dais* have been organised into existing district-level women's associations that are part of the SEWA movement.

Each cooperative has an elected executive committee that runs the cooperative and plans and manages all the health activities for the district concerned. It generates revenues in various ways: from women, from employers, from the government, through training fees and from medical shops.

Health insurance has been organised for SEWA members with the support of SEWA Bank; 32,000 women have paid the premium for coverage, which includes maternity benefits, reproductive health, occupational health, health problems of older women and other common or serious ailments. Each woman receives coverage of up to Rs.1300 per annum.

2. A ‘Shakti Packet’ programme is being run by village women and provides food grains and other essential food items to women in two drought-prone districts.

3. ‘Shakti Packets’ ensure that poor women and their families obtain food items of good quality and in correct quantity — and hence proper nutrition — at affordable prices at their very doorsteps.

4. Basic amenities have been provided in 11 poor urban neighbourhoods in Ahmedabad in collaboration with the Ahmedabad Municipal Corporation (AMC) in a unique joint programme called ‘Parivartan’.

Under ‘Parivartan’, AMC local corporate bodies and poor families themselves contribute towards the provision of health-enhancing basic services: water toilets, gutter connections, garbage disposal, street lighting, the paving of roads and by-lanes, and landscaping (filling and levelling ditches to grow trees that provide shade). Finances of individual families are managed by SEWA Bank, which also provides them with loans and releases the deposits made by the families to the AMC when substantial ground work (laying of pipes, etc.) is completed.

5. In Ahmedabad city, women run three round-the-clock drug counters to provide standard quality, low-cost drugs and surgical equipment to poor patients. A recent evaluation of this activity found that the counters’ prices were the lowest in the market. This has forced nearby chemists to revise their exorbitant rates.

At present, four new drugs counters are being developed to serve our rural members. One of these is located in a taluka town.

What We Have Learned

1. Women’s priority is work security and income security. But without appropriate and affordable health care, they can obtain neither work and income security nor full employment and self-reliance.
2. When women organise for and obtain some measure of work security, they seek and demand health security and health care.

3. Women view reproductive health as an integral part of their overall health. Treating this as a separate aspect of their health is not useful to women.
4. Occupational health is a very neglected aspect of women's health; it is also one where it is difficult to intervene in a meaningful way. This is because:
 - Women are afraid of losing their employment in a situation where alternative employment is scarce (as in the case of tobacco workers), and hence are not eager to take up occupational health activities.
 - Safe workplaces often require major changes in work processes and substitution of toxic substances. This is something that employers do not want to undertake on the grounds that it would be too 'expensive'. In addition, lack or paucity of unions means that the women have very little bargaining power.
 - Occupational health interventions often need to be technical and scientists with an interest in working with and learning from the poor are hard to come by.
5. There is a tremendous hunger among women and men to learn about their bodies and their health. All they need is simple, understandable and appropriate health information – information that is both useful and empowering.
6. Health care/services can be a source of employment, especially self-employment for poor women. For example, they can become health educators and charge fees for their midwifery and drug supply services.

Cooperatives of health providers like *dais* can be active and economically viable organisations.

7. Decentralisation of health services and delegation of the latter to women's groups and organisations (unions, *mahila mandals*, cooperatives and producers' groups) is an effective way to reach health care to the poorest populations. It is the ideal alternative to

both government and private health care, which are generally neither pro-poor nor women-centred.

8. Combining a strong grassroots base with policy action can help in the development of health policies and programmes that reflect the health priorities of poor women. Policy action may be undertaken at district, state, national and international levels. For example, SEWA's long-standing demand for identity cards and hence recognition of *dais* has been accepted by the Gujarat government. Various plans to involve these local women health care givers in primary health care activities are being worked out.

Perhaps the most important lesson that we have learned in all these years is the importance of organising – i.e., when women workers come together in a group around common interests, including their own health, they become a powerful force for change — change in their own lives, their communities and the world beyond their villages. Only they can take the lead to ensure their own and their families' overall health and well being.

Chapter 5

Men's Involvement in Women's Health Learnings from SARTHI

Renu Khanna, Harish Patel, Balwant Pagi and Nirmal Singh

SARTHI – Social Action for Rural and Tribal Inhabitants of India – is a registered society working for integrated rural development in the Santrampur Taluka of Panchmahals District in Gujarat. The voluntary agency, founded in 1980, is working in approximately 150 villages of this predominantly tribal taluka. Much of the population consists of marginal farmers who are dependent on rain-fed agriculture and who also have to migrate seasonally. Programmes undertaken by SARTHI include: installation of hand pumps for drinking water, agricultural improvement, wastelands development, education through eight non-formal schools, rural industries for income generation, development of alternative energy sources, and women's development and awareness generation.

In the early years, SARTHI's work could be categorised as pure service delivery in which SARTHI functioned as an implementing agency and the villagers as the 'beneficiary community'. Later, around 1988-89, along

with service delivery, organisation and empowerment of village communities to become partners in the service delivery, became an important component of SARTHI's work. This meant that there was a lot more dialogue and discussion with the village people, and formation of village-level groups (separately for men and women) to help plan and implement development programmes.

Evolution of the Women's Health Programme¹

In 1987, responding to the demands of the local women, SARTHI decided to train a carefully selected group of *dais* (traditional birth attendants) and other interested local women to carry out a Maternal and Child Health programme. From 1989, in collaboration with traditional healers and herbalists, SARTHI carried out action research on local plant-based medicines traditionally used by women for their health problems. Simultaneously, with the help of Shodhini² resource persons, eight *arogya sakhis* (barefoot gynaecologists-cum-counsellors) were trained in the period 1990-91. The *arogya sakhis* were closely guided in their practice and use of local medicines, which underwent a process of validation by the resource persons.

The various components of the health programme were characterised by:

- gradual building up of the knowledge and skills of local women to respond to local health needs.
- continuous and sustained support from external resource persons in terms of both training and monitoring.
- use of local resources such as herbal medicines, government health fieldworkers, and the government health structure for secondary care.
- a model of research that was based on local people's agenda, and directed and owned by the local people (participatory action research).

Box 5.1 shows the major milestones of how men's involvement came about.

Box 5.1
Major Milestones in Men's Involvement
in Women's Health Programme

December 1984	Initiation of a women's empowerment programme through an improved <i>chulha</i> project.
July 1988	Initiation of a women's health and empowerment programme.
February 1990	Evaluation of the Women's Health Programme, including Men's Perception Study. Initiation of a general community health programme in 60 villages.
July 1992	Insight that STDs may be a major problem.
September 1992	Training on STDs for male health-workers. Self-help group meeting of <i>arogya sakhis</i> – input on STDs.
October 1992	Meeting of male health-workers and <i>arogya sakhis</i> to plan for team work on STDs.
April-August, 1993	Project formulation exercise: 'New Directions in Reproductive Health: Action Research on Community-based STD Management Programme'.
July 1993	Refresher training on STDs at SEWA Rural, Jhagadia.
April 1994	First clinical diagnostic and treatment camp for STDs in men and women.
August 1994	Second clinical camp.
August-Sept 1994	Qualitative studies on <ul style="list-style-type: none"> • Men's perceptions of illnesses of the 'nether' area. • Attitudes and perceptions of men and youth about sexuality and related matters.
April 1995	Reorganising the health programme based on experiences during the research phase: team approach to sexual health.
September 1996	Fertility Awareness Education Training for male health-workers, women health staff, and village-level volunteers: ' <i>vansh velo talim</i> '.
January 1997	Two health programme coordinators go for three phases of the WAH! Training.

June -Sept 1997	Gender and health training for village-level health volunteers.
February 1998	Initiating work with adolescent youth in 10 villages.
May 1998	Gender and sexual health education programme with groups of newly married couples.

Evaluation of Women's Health Programme

Besides looking at the effectiveness of the training given to women health-workers (WHW), when we evaluated the Women's Health Programme in 1991 we also studied the differences in the perceptions of men and their levels of awareness in the (experimental) project area and the non-project area with respect to the quality of health care given to the women of the area. The data sets of the males were of three types – husbands of lactating women, husbands of pregnant women and men in general.

The findings of the evaluation were interesting. Responses from husbands of currently pregnant women indicated that many more husbands from the project area as compared to the non-project area were aware of the special care that their wives needed during pregnancy, and whether their wives had taken tetanus toxoid injections and iron-folic acid tablets. More men in the project area (69 per cent) than in the non-project area (around 35 per cent) stated that the birth attendant told them of the care that their wives required during pregnancy and delivery.

Among husbands of lactating women, more men in the project area stated that their wives had problems in their latest deliveries. This could be an indicator of a higher degree of awareness among these men as a result of the health education efforts of the WHW. Knowledge about breastfeeding, weaning and immunisation schedules was also better among men in the project area. Again, more men in the project area were informed by the birth attendant about the care required by their wives.

Though the general perception of men in the region was that women fell ill more often than men, more men from the project area seemed to think so. Similarly, more men in the project area acknowledged that women's illness causes inconvenience to the family and that women have to bear

greater hardships in life. As compared to the men from the non-project areas, more men from the project area were of the opinion that the women's meetings routinely conducted by SARTHI activists in the villages should be continued, and that men should help with cooking and taking care of children while women attend these meetings.

Thus, the evaluation showed that though men had not been consciously considered as a target group, SARTHI's work on women's health has indirectly resulted in increasing their knowledge and sensitivity, especially of those in the project areas, to gender issues.

Initiation of a General Community Health Programme

Phase 1

This finding encouraged SARTHI to think actively of developing a health programme that addressed men as well. Fieldworkers also reported that the villagers kept asking them, 'Why are you only providing health services to women? Don't you think men and children get sick too?' Prodded by these kinds of demands, SARTHI decided to initiate a general community health programme (CHP) to

- (i) create health awareness in people;
- (ii) provide services for primary health care at the village level;
- (iii) inform people about their rights vis-à-vis the government health services.

In April 1991, a group of 15 carefully selected young men from six clusters of villages were trained as health-workers. They were helped to plan a health programme that would cover 30 villages through the organisation's six field centres.

By 1992 there were three different strands of health work going on in about 75 villages that formed SARTHI's field area. In about 20 villages, *dais* were doing MCH work; in nine villages, *arogya sakhis* were working as 'barefoot gynaecologists-cum-counsellors' and in 60 villages, male

health-workers were carrying out community health work.

Training for sexually transmitted diseases: In the ongoing monthly meetings and *shibirs* (camps), *arogya sakhis* constantly brought back reports of women with vaginal infections, whom they treated with locally available herbal preparations. It was evident from the case histories that many of the infections were sexually transmitted. Since it was observed that simultaneous treatment of the partners helped in relieving the women's symptoms, *arogya sakhis* were provided information on various types of Sexually Transmitted Diseases (STDs) through slides and photographs. Posters were used by field staff to initiate discussions on STDs in the community. Among other things, these discussions revealed the locally used terminology for STDs: 'garmi', 'chaandi', 'parmio'.

It was also realised that by working only with the women, the incidence of STDs in the community could not be controlled. For the strategy to be effective, it had to be extended to the men as well. Thus, SARTHI's male health-workers were also provided training in STDs.

It was hoped that a series of training programmes would equip the *arogya sakhis* and male health-workers to talk about STDs in the villages and this, in turn, would encourage people to talk about what had so far been taboo subjects.

Learnings from Phase 1: The pilot phase of the programme (1988-1992) yielded several important lessons for the programme planners at SARTHI. It was realised that

- village women and traditional *dais* can be key actors in woman-centred health programmes.
- women health-workers require various kinds of support structures in terms of guidance, back-up for secondary care, and the production and distribution of medicines.
- involvement of the male staff in the programme is necessary to sensitise men to gender issues.

Some of the other important points that surfaced were that:

1. In a tribal area, where there is a high incidence of seasonal migration

for wage labour, and where cultural norms favour multiple sexual partners, it would be necessary to develop a systematic STD control programme.

2. Men would have to be included in the women's health programme to reduce morbidity in women due to STDs. This would necessitate obtaining information on men's sexual behaviour patterns to determine how they affect women's reproductive health. Most importantly, it would be necessary to create greater awareness and sensitivity among them regarding gender issues. Health education would therefore also have to target men.
3. Efforts to improve women's health status should start when they are adolescents. Girls should be included in the programme because efforts at empowerment come too late if they are approached after they are married; by then, they are already caught in the web of powerlessness that is characteristic of husband-dominated family structures. The responsibility of looking after the children only adds to their powerlessness. Thus, the earlier young girls learn to make decisions and control their lives, the easier it would be for them to be in charge as adults. Adolescent boys also need to be included because gender sensitisation and the construction of new models of masculinity can be more successful when the boys are still growing up and are therefore more malleable and receptive.

Phase 2: 1992-1995 – Action Research on STDs

During this period, SARTHI was supported by the Ford Foundation for an action research project on community-based STDs management. A qualitative research component was included to understand how men and women of the area perceive STDs and Reproductive Tract Infections (RTIs) and the impact these have on their lives. On the basis of this research, a programme on STD management was initiated in 60 villages. The programme, which is still continuing, is directed towards men, women and adolescent girls and boys. A cadre of village-level male and women health-workers has been specially trained for this work by the older staff who were involved in the research. Box 5.2 shows components of the STD Programme.

Box 5.2

Components of the STD Programme

The main components of the programme are:

- culturally relevant health education on STDs;
- a motivation programme for condom use and a condom distribution programme;
- diagnosis and treatment of simpler STDs;
- referral (and escorting) to the nearest secondary health care facility providing treatment of STDs.

Learnings through the research process: Between April and August 1994, SARTHI organised two clinical camps for the diagnosis and treatment of STDs and RTIs in men and women.³ The low level of response to these camps highlighted an important lesson — that access to health care by women is not just a matter of *physical access* but also of *social access*. The factors that deter women from seeking treatment for reproductive health problems are their own fears of internal pelvic examination, the consequences of a positive diagnosis on various facets of their life, and what men in their family may have to say about such illness. Many women who had earlier reported symptoms (50 per cent of the sample) and agreed to get themselves examined and treated at the camp, backed out either because their husbands (and other older men in the family) refused them permission, or because their husbands were away. 'Without asking him, I cannot get myself examined,' was the general refrain. If the agenda to increase women's access to health care were to become a reality, it would be necessary to include in the programme sensitisation of men, especially husbands, to women's health needs.

The experience of doing qualitative studies with men also yielded a rich crop of learnings. SARTHI did two small studies on (a) men's perceptions of illnesses of the 'nether' area, and (b) attitudes and perceptions of men and youth about sexuality and related matters.⁴ At the time of project formulation, it was decided that all the data collection would be done by SARTHI field staff. This was envisaged as a capacity building exercise to sensitise the fieldworkers to issues of sexual health and sexual behaviour and help boost their confidence and increase the skills required

for handling these matters sensitively in the field. The fieldworkers were all local young men with 10 to 12 years of schooling. The only external member of the team, a non-tribal, was the research officer who coordinated the fieldwork and trained and supervised the fieldworkers.

The research team's lack of experience in talking about matters related to sex affected the research process in several ways.

- (i) The research officer, a man of a different cultural and class background, had his own prejudices and set of moral values that affected the training and ongoing feedback that he gave to the tribal fieldworkers.
- (ii) The differences in age between the young fieldworkers and the respondents, many of whom were older men, also created barriers in communication. The fieldworkers felt that it was not right to talk about sex and related matters with respondents who were old enough to be their fathers.

These difficulties indicated that fieldworkers had to overcome their own internal barriers and increase their openness and sensitivity in relation to sexuality. Having earlier faced a similar situation with the *arogya sakhis*, it was realised that male health-workers also needed to go through a process of learning about sexuality by discussing their own experiences, feelings and fears. This would help them to talk with greater ease with men and youth in the community.

Phase 3: 1995: Reorganising the Health Programme

Beginning April 1995, SARTHI decided to reorganise its health programme. Instead of dividing the programme into two separate components of women's health and community health, it was decided to address gender issues in community health with a special focus on women's health.

In line with the new programme objectives (Box 5.3), the staff structure was also changed so as to ensure that each village had a team comprising of one male and one female health volunteer who would complement each other in their work. While the female health volunteer would deal with the woman client, the male volunteer would talk to her partner and

other significant males in the household.

Box 5.3

Objectives of the New Health Programme

In addition to existing services for common health problems, the new programme aimed to

- increase awareness among men and women of gender issues in health;
- promote the use of condoms and safe sex practices;
- promote ANC for women, attended deliveries and referrals if necessary;
- increase referrals for infertility, uterine prolapse, pap smears, etc.;
- increase the number of TB patients completing their treatment, and
- provide basic counselling and treatments for gynaecological problems.

The reorganisation effort had mixed success. For instance, it led to greater coordination between male and female health-workers. Wherever necessary, they told each other to follow up on the partners of the persons they had been meeting. Secondly, it facilitated a greater understanding of how gender operates in the area of health, enabling health-workers to initiate appropriate actions aimed at gender equity. On the negative side, it was difficult to manage the gender dynamics between men and women health-workers within the team. Sometimes the older, more experienced women staff dominated their male colleagues. At other times, the educated and more mobile younger male staff exerted power over their women colleagues.

Fertility Awareness Education Training

In 1995-96, SARTHI organised a series of training workshops for men and women health staff to improve gender relations at various levels, and to equip them with the knowledge and skills to work on fertility awareness and related issues like contraception, infertility, and so on. Dr. Mira Sadgopal, a community health-worker, trainer and fertility awareness educator, conducted the workshops.

The specific outcomes expected after the training were:

- (a) Improved communication and sharing of responsibilities among men and women at various levels:

- (i) within the SARTHI health programme team;
 - (ii) within their families: between partners and spouses;
 - (iii) at the community level: among men and women health volunteers, the village health committees, and among men and women in the villages.
- (b) Provision of an increased range of services at the community level: counselling for contraception, abortion, infertility, etc.
- (c) Greater involvement of men in sexual health issues.

The staff named this training process as the '*vansh velo talim*'. The terms '*vansh*' (family or dynasty) and '*velo*', or '*bel*' (a creeper) capture beautifully the idea underlying fertility awareness education. *Vansh* brings out the aspect of social fertility, and *velo* the aspect of cycles that are progressive. The contents of the *vansh velo* workshops are given in Box 5.4.

Some highlights of the *vansh velo talim*: In keeping with the idea that learning to talk about sexuality would only happen if male staff began talking about their own concerns and conflicts, a few sessions titled '*shareer se dosti*' (or making friends with the body) were designed. These were initiated through a body mapping exercise wherein participants were asked to first mark on a body outline the parts which gave them '*dukh*' (or pain) in red, and the parts where they felt '*anand*' (or pleasure) in green. All the participants were extremely enthused during this exercise and soon the outline of the body was marked with red.

The next round featured the pleasure areas. In contrast to the first round, the participants had to be really coaxed into marking the pleasure areas. Even after a great deal of persuasion, five or six participants did not respond.

'*Savaali Ram ni Peti*', or Mr. Question Box, proved to be a popular idea. *Savaali Ram* was a box into which, over a period of time, participants could put in their written questions or concerns related to sexuality. Since they were not required to sign their names to the questions they wrote on the slips of paper, both anonymity and confidentiality were assured. During the *vansh velo talim*, *Savaali Ram* was opened and a

Box 5.4

Contents of *Vansh Velo Talim*

Topics

- Fertility awareness and fertility awareness education, infertility.
- Concept of cycles, how fertility is linked to cycles, beliefs around menstruation.
- Making friends with our bodies, body awareness, body mapping exercise to identify areas of pleasure and pain, to identify how we communicate through our body: receiving and transmitting communication.
- Internal organs and systems within the body, relationship of reproductive system with the brain and endocrine system.
- Contraception in relation to fertility, cycles, conception
- Sexuality: *Savaali Ram*: anonymous questions answered by a male gynaecologist
- Gender, XY chromosomes; *stree purush samaanta*; what do I want to be, man or woman, in my next birth? Why?

Homework

- Interview men in the villages, find out about beliefs, practices and men's role in conception, pregnancy, childbirth, breast-feeding and responsibilities as a father.
- Keep a personal diary to record own cycles and explore your own cycles.
- On the body outline, ask your partner to mark out which parts give her pleasure and pain. And you tell her about your areas of pleasure and pain; communication with partner; share with your partner what you appreciate about her. Ask her to tell you what she appreciates in you.
- Do *Savaali Ram* in the village. Ask boys or men to put in their questions in the box. Come back, find out answers and then give them responses during the next field visit.
- Identify couples who are trying for children through *arogya sakhis*. Interview and counsell them.
- Consolidation of learnings into IEC messages for men on contraceptives
- Think of ways the male staff can work with boys and men in the villages.

Feedback and discussion

- Homework topics
- Difference in my personal and work life after the first *vansh velo talim*.

male gynaecologist, who was one of the resource persons, read out each question and answered it. Box 5.5 provides a sample of the questions

Box 5.5**Some Frequently Asked Questions**

- If a woman gets married late, why does she have difficulty in becoming pregnant?
- If a man does not desire sex but the woman wants it, what can be done? Why does this happen?
- What can a man do if he does not have a sexual partner?
- Why does the penis not increase in size?

asked.

Each question was answered in detail. The responses were also sympathetic towards women and not moralistic or prejudiced. The male staff felt considerably encouraged to raise further questions. On the basis of this experience, the health-workers decided to introduce *Savaali Ram* in the villages. Village youth and men could anonymously put in their questions into the box and these would be answered by the health-worker in monthly meetings. As a way of equipping themselves to answer such questions, the resource person suggested that health-workers read the weekly question-and-answer sexology column in a leading Gujarati newspaper.

Women and Health (WAH!) Training

Apart from the *vash velo talim*, a male and a female coordinator of SARTHI's health programme were sent for the three-month long WAH training. This training programme aimed to groom field supervisors and coordinators into 'managers' of women's health projects. The main elements of the WAH training were:

- A feminist understanding of women's health;
- Management skills for planning and monitoring a women's health programme;
- A perspective which respects local health traditions, including herbal medicines;
- An understanding of gender issues in health.

Participation in WAH made the two coordinators more confident, assertive and articulate. Among other things, they organised a series of gender training workshops for their own team members as well as sessions for the villagers in general.

Group sessions with adolescents – both girls and boys — have also started. In 10 villages, monthly group meetings are held separately with boys and girls. These meetings, held over 10 months, include discussions on specific topics (see Box 5.6). Participants are also free to discuss other matters that are of concern to them. Several confidence-building and empowerment exercises are part of these sessions.

Box 5.6
Topics of Monthly Discussions

- Anatomy and physiology of males and females.
- How conception occurs.
- Contraceptive methods.
- Love and sex in caring and responsible relationships
- How gender operates in our lives.
- Violence and sexual abuse.
- Infertility.
- Nutritional needs of men and women through different stages of their lives.
- Care required during pregnancy, childbirth and lactation.

Learnings

The involvement of men in SARTHI's women's health programme has yielded several lessons for the SARTHI team. This section highlights some of the more significant insights and learnings.

Meaning of Empowerment in the Context of Reproductive Health

SARTHI's Women's Programme aimed at women's empowerment, which was recognised as both a process and an outcome. The group defined empowerment as 'enabling women to analyse their own situation; to

decide their priorities and develop solutions to their problems and take collective action to improve various aspects of their lives.' SARTHI's definition of empowerment thus had elements of both self-determination and control over resources.

It was felt that one possible way of conceptualising manifestations of empowerment in the context of women's health could be as follows (Table 5.1):

Table 5.1 Manifestations of Women's Empowerment			
Intra-personal	Inter-personal	Group	Community
Building confidence in self, shedding of <i>sharam</i> (shame), owning one's body, beginning to talk about what affects that body and its health.	Awareness and increasing control over relationships through which the body is affected.	Appropriating health services that rightfully belong to the group.	Organising for collective action, demanding and getting quality health care; dealing with issues that affect the health of women, e.g., violence.

Table 5.1 indicates that empowerment of women can be manifested along a continuum. At an intra-personal level, empowerment begins when individual women change their perception of themselves. What they earlier thought of as dirty and a cause for *sharam* (shame, embarrassment), they now begin to claim and own. The physical problems, which were earlier shrouded in silence, were now discussed and brought out into the open. At the inter-personal level, women began to realise how certain relationships and their subordinate role in them directly affect their bodies. An example of this is the relationship with their husbands. In small ways, they also begin to negotiate relationships in the larger environment. For instance, a small group of women would decide to accompany their neighbour to the health centre to make sure that she got the service she required. At the community level, women began to organise themselves for collective action around their own issues, e.g., to pressure the state to ensure that their health rights are met, or to draw attention to issues

which affect their bodies and health directly but which, until recently, were not being addressed, such as rape and violence.

The phase of qualitative research, wherein SARTHI health-workers spoke at length with the village men and youth on their understanding of sexuality and illness, revealed an unsuspected degree of vulnerability among men. In particular, group discussions with boys provided an insight into how male sexuality was socially constructed. The boys felt that they had to brag about multiple sexual relationships, about early initiation into sexual activity, etc. And yet, in individual conversations, the same boys expressed anxiety and insecurity related to the size of their penis, masturbation, and so on. Their state of disempowerment came through very clearly.

SARTHI's current understanding of empowerment has thus expanded. The group believes that power has to be defined not in terms of 'power over others' but in terms of self-reliance and inner strength, and the ability to determine choices and exercise control over one's own life. This holds true for both women and men. Just as women need to liberate themselves from the stranglehold of patriarchy, men too need to free themselves from patriarchal constructs of masculinity.

Meaning of Access to Health Care

Access to health does not just mean easy availability of health services in physical terms, such as the existence of a health centre, equipment and doctor. There are also social aspects of access to health care. Some of these are:

- Health services that meet the expectations of the community's belief system in the context of disease and wellness.
- Gender relations that facilitate early recognition of women's illnesses and encourage them to seek early treatment.

If sick women cannot access health services available in their villages because they have to ask permission from the men in their families, then physical access may be there but not social access. Thus efforts at improving women's access to health care should aim not only at setting up and improving health care services that women can reach easily, but also address social factors that impede women's access to these services.

Meaning of Men's Involvement in Reproductive Health

Once SARTHI recognised that men are not a homogenous group, it realised that to increase men's involvement they would have to work with at least four different groups of men: SARTHI's own male staff, the husbands and other significant men in the families, the '*vadilo*' or elder men who represent the power centres in the village community, and adolescent boys. The agenda with each group of men is different. Male staff need sensitisation on gender and women's health issues, and the building of requisite skills to work effectively in the villages. Husbands and others in the family need information on women's special needs related to their role in reproduction, and how they can support the women through the various phases of reproduction and other illnesses.

Men also need to be made aware about how their behaviour as sexual partners can affect women's health. Village elders and community leaders need to be informed about women's sexual health concerns so that they can facilitate early detection and treatment seeking. Adolescent boys, too, need information on their own sexual concerns. In addition, they need to be helped to discover the meaning of mutually respectful and caring relationships.

Thus male involvement in reproductive health is far more than just promoting vasectomies and condoms, as is commonly assumed.

Learning to Talk about Sexuality

Training of male staff cannot be restricted to clinical sessions on STDs. Responding meaningfully to men in the community on sexual health issues within the framework of gender equity requires a perspective and skills that need to be specially and carefully built. Personal transformation, empowerment and changes in one's own gender relations are necessary before male health-workers can become good role models in the community. Male health-workers need to talk about and resolve their own issues and concerns related to sexuality before they are able to talk confidently and effectively in the villages. Training on sexual health thus needs to be experiential and participant-centred rather than clinical and trainer or topic-centred.

Role of the Male Health-worker

As has been seen, men's involvement in the reproductive health programme is complex and multi-faceted. The male health-worker plays a very important role, and the Government of India's Reproductive and Child Health programme needs to take cognisance of this fact and redefine the role and training of Male Multipurpose Workers.

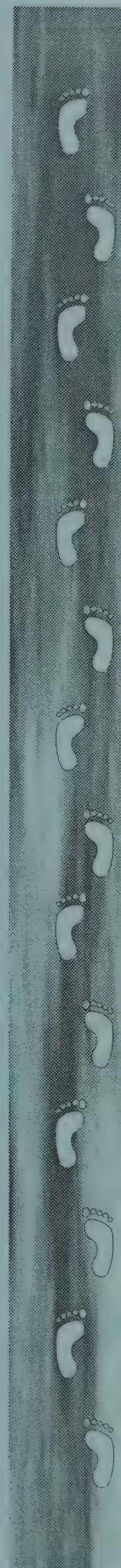
Notes

- 1 For a detailed report of the health programme, see Renu Khanna, 'Taking Charge: Women's Health as Empowerment – The SARTHI Experience', SAHAJ/SARTHI, Baroda, 1992
- 2 Shodhini is a network of women in India who have been working for alternatives in women's health based on self-help methodology and plant-based medicines. See *Touch-me, Touch-me-not: Women, Plants and Healing* (Kali for Women, New Delhi, 1997) for a complete report of Shodhini's work.
- 3 For learnings and experiences from the clinical research phase, see Renu Khanna, 'Dilemmas and Conflicts in Clinical Research on Women's Reproductive Health', *Reproductive Health Matters*, No. 9 May 1997.
- 4 See 'Evidence from Qualitative Studies conducted in the Santrampur Taluka of Panchmahal District, Gujarat'. Working Papers 3 and 4, 'Men's Perceptions of Illnesses of the "Nether Area" and 'Attitudes and Behaviours of Men in relation to Gender and Sexuality', 1996 and 1997, respectively.

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Part 2

Training for Women's Health



Chapter 6

WAH! Training Programme

Southern Region

Philomena Vincent

The WAH! programme was launched with the objective of creating women managers for women's health programmes. The ultimate goal of WAH! is to effect an improvement in the health of disadvantaged women in rural areas by providing gender-sensitive management training to health coordinators while emphasising self-help and promoting local health traditions to empower women. WAH! recognises that women have been making a valuable contribution to health care, both at the household and community level. It also acknowledges that a significant part of the human resources working in the health sector are women. In its endeavour to supplement and strengthen women's traditional knowledge, WAH! has identified the need for a synthesis of the following components within the women's health care programme:

- Expanding the definition of women's health beyond just maternal and child health.
- Building the capacity of coordinators and health personnel to use traditional knowledge systems and self-help as a tool of empowerment and well being.

- Organising gender-sensitive management training to help health personnel, especially women, to become health managers.

In pursuance of these objectives, in 1992 WAH! constituted a core group which was responsible for coordinating the WAH! programme at the national level, developing the curriculum design and structure of the programme, providing pre- and post-training support, financial planning, supervision and monitoring of the programme as well as establishing contacts with other NGOs and government agencies. However, in a Planning Workshop held in the same year, it was decided to implement the WAH! programme at the regional rather than at the national level. Regional core groups were therefore formed at this planning workshop and the curriculum was finalised. In December 1993, a pilot training programme was launched for the Southern Region covering the states of Karnataka and Tamil Nadu.

The Society for Human and Social Development (SHSD), based in Bangalore, in collaboration with its sister organisation Aikya (see Box 6.1), served as the training institution for the WAH! programme. Besides academics, bureaucrats, the corporate sector, small businessmen, students, etc., SHSD provides human resource development training to rural communities. SHSD's training is based on an eclectic approach that combines traditional wisdom with modern management skills. Aikya, a field-based training organisation, also located in Bangalore, is involved in providing opportunities for rural and urban communities to improve their livelihood and quality of life. Box 6.2 gives an idea of Aikya's health programme. SHSD uses the Aikya training centre for its programmes. A brief account of the pilot training programme for the Southern Region is given in the following section.

Selection of Participants

The core group recognised that effective implementation of the programme would depend on a careful selection of the NGOs which participate in it. At a meeting of experts in 1993, a set of selection criteria was therefore laid down for use by the regional core groups. These included: experience in women's issues as well as in women's health matters, commitment

Box 6.1**Aikya: the Organisation**

An activist and training group, Aikya works with indigenous folk practitioners, especially women healers. It was established in 1982 with the objective of providing the rural poor, the tribals, the dalits and the landless, and especially women and children among them, with new opportunities and options for achieving a better quality of life. Aikya's work is based on the assumption that, in India, change will only occur when the poor and other marginalised groups, especially women, begin to take greater control of their lives and become part of public decision-making bodies. Over the years, it has succeeded in reaching out to rural communities spread across 300 villages.

Today, Aikya has grown to become a field-based training organisation for helping people rediscover and organise their potential for improving the quality of their life in the areas of work, education, health and culture. The field offices of Aikya are located in Tarikere, N.R. Pura, Vellimalai in V.R.P. district and in South Bangalore.

Aikya's work is rooted in ground realities and its programmes include Gender Awareness Training and Organisation Building. Working with children forms an important part of its agenda.

to women's health and empowerment, experience in community health and implementation of socio-economic education programmes, and organisational credibility as well as training and organising capacities. It was decided to give preference to support organisations with field-level experience, especially those working in communities where grassroots-level groups have already been formed.

Two rounds of selection workshops were held in Karnataka and Tamil Nadu to introduce the programme to the NGOs and to learn about their background, motivation, needs and expectations. It was not possible, however, to strictly adhere to the selection criteria while finalising NGO partners and trainees. First, there were not many women in managerial positions and the concerned NGOs could not afford to send staff for such long-term training without creating organisational problems in the office and the field. Second, since most NGOs with health programmes,

operated only within a modern medicine framework, they were suspicious of traditional medicine. Third, the launch of the pilot training programme in the Southern Region was seriously constrained by the demands of the donors' funding cycle.

Given these limitations, it was decided that training partners be selected from among the NGOs already known to SHSD and involved in women's development, familiar with alternative practices in health work, and willing to commit their organisations for this women-centred health management programme. Still, not many of these were able to release responsible women staff for several weeks of training at a time. Finally, nine NGOs joined the programme. Six of these — Mahila Samakhya (in the city of Bangalore and Bidar, Bijapur and Gulbarga districts), Aikya in Chikamagalur district, Coorg Organisation for Rural Development (CORD) from Coorg district — were from Karnataka; the remaining three — Aikya Klavaryan Hills, Anthyodhya Sangh (Tiruchirapalli) and Nature Trust (Pudukottai) — were from Tamil Nadu. Of these, Aikya (Chikamagalur) and Mahila Samakhya (Gulbarga and Bidar) fulfilled the selection criteria, though Mahila Samakhya works on a larger scale than Aikya. Both these organisations have a long-term interest and commitment to women's empowerment and health, a qualified and highly motivated staff, a strong base in the community through women's *sanghas* and a focus on poor, disadvantaged women of the lowest castes. Among the others, though CORD, Anthyodhaya Sangh and Nature Trust were not specifically working towards women's health and empowerment, they had sound experience in grass-roots level work and were committed to the promotion of indigenous health systems.

The pilot course started with 24 women trainees, of whom 15 could attend all the phases. They were all women's health and development workers employed by the nine NGO units.

Though the training was aimed at senior and middle-level personnel who held key decision-making positions in women's health projects and programmes, only middle and grassroots-level personnel from diverse backgrounds and job responsibilities could be selected for the training. This, as mentioned earlier, was mainly because the NGOs could not spare their senior-level staff, as their absence would have affected their existing

programmes. Again, due to time constraints, it was not possible to organise a prior orientation workshop or even a meeting of all partner NGOs, giving them time to prepare themselves to depute a senior staff for the training and adjust their project schedules and responsibilities accordingly. Participants therefore had to be selected from among middle and grassroots-level staff, particularly those whose absence would not have adversely affected the NGO's programme or project.

The participating staff of each NGO had different roles and responsibilities within their respective organisations as well as within their programmes. They were thus different not only in terms of their roles and experience, but also in terms of their educational background. Most of the 24 participants had completed primary/middle or high school; a few had attended college, though only one was a graduate. Only three of the participants were neoliterate; however, they were knowledgeable, traditional healers and held responsible positions in their respective teams. Despite this heterogeneity, the participants were highly motivated to acquire new skills and to sharpen their existing skills in primary health care management and the use of traditional systems of medicine.

Content and Design

The course aimed at enabling the trainees to take charge and build women-sensitive health projects and programmes and to contribute to their professional as well as their personal growth. Drawing from both traditional and natural healing as well as modern medicine and public health, the training comprised three modules that had been developed earlier in the WAH! programme planning phase. These included:

- Women's health concerns;
- Women's health care capacities; and
- Women's health management.

The SHSD team modified the course design to suit the resources and requirements of the Southern Region and of the group of trainees from Karnataka and Tamil Nadu. The topics included in the course were:

Health Concerns and Capacities

- Promotion of health.
- Body structure and functions.
- Nutrition; water and sanitation.
- Girl: infancy – child – adolescence.
- Gynaecological and reproductive health.
- Simple skills of diagnosis.
- Disease management, use of herbs.
- Local traditions, herbal medicine.

Management Issues and Skills

- Exploring one's self and others.
- Management in organisations.
- Boundary and system management.
- Action research and project planning.
- Herbal garden management.
- Managing a herbal medicine unit.
- Holistic health care management.

While a major part of the training (Phases 1 and 3) was held at Aiyka's rural training centre located in Galligudda outside Bangalore, the first half of Phase 2 training was held at the Vivekananda Girijina Kalyan Kendra (VGKK) Health Centre in the B.R. Hills of Mysore district. Besides a visit to the VGKK herbal garden, field trips were made to Dhanvantri Vana, a herbal garden and medicinal plant nursery, and Siddharu Betta, a forest area in the Sanjivani Hills near Tumkur district, rich in herbs and medicinal plants, to meet the local *siddhas* (local herbalists). These trips helped participants gain practical experience in the identification, processing and propagation of medicinal plants, and in planning and managing herbal gardens. Participants also went on a field visit to the Women's Health and Development Organisation project in a slum settlement of Bangalore city, to get exposure to three major aspects of women's health programme management: integrating class and gender issues into a women's health programme, intersectoral coordination between NGO and government health services, and systematic

documentation and record-keeping.

Besides field trips, the training programme also included occasional cultural events like a classical music concert and dance performance.

One of the key insights that Aikya has gained is that the urban educated are often strangers to this herbal heritage that has been passed down to us through the ages. The folk healers may be poor and non-literate, but they are survivors and living examples of our rich, oral health traditions.

In addition, since 1995, Aikya has begun developing a Health Resource Centre near Bangalore for the preparation and promotion of herbal medicines. The centre also supports the development of indigenous health practices in primary health care, especially for women, through residential training.

Resource Persons

The training was conducted by a team of experienced, highly qualified and committed resource persons. These included management specialists, allopathic and ayurvedic doctors, public health experts, social scientists, botanists, community development specialists and activist from the women's health movement. Their experience in training grassroots NGO workers enabled them to relate to and effectively communicate with rural participants who did not have high levels of formal education.

Highlights of the Training Process

As has been mentioned earlier, the training was conducted in three phases. The first phase was held from 20 February to 3 March 1994 at the Aikya rural training centre at Galligudda. The emphasis was on perspective building, women's health concerns and healing concepts, understanding oneself, exploring role relations, and learning basic communication and management skills.

In the second phase (Box 6.3), held from 24 July to 20 August 1994, the emphasis was on developing health care capacities by deepening participants' understanding of problems, especially women's illnesses; learning simple diagnostic and treatment and prevention skills using herbal

Box 6.2

Aikya's Health Programme

Aikya's health programme has become an important part of its work among rural communities. Its philosophy is to respect, nurture and support folk health practitioners and upgrade their expertise. Based on this philosophy, a health programme was launched in areas like the Kalvarayan Hills in Chikamagalur district with the following objectives:

- Documenting the health practices and remedies of traditional health practitioners, with a particular focus on women's health problems; identifying the most effective health practices with the help of practitioners and promoting the use of traditional health knowledge to enable women to gain control over their body and its healing.
- Organising '*Arogya Sanghas*' (health collectives) at the village level, and through these, holding meetings with local women to discuss their general health concerns and reproductive health problems.
- Organising self-help workshops for training women healers and health-workers to diagnose and treat common gynaecological ailments at the primary level.
- Enhancing skills to set up herbal/kitchen gardens for local use as a natural health resource.

medicine; and the basics of health care management. The basics of diagnosis in both the traditional and Western systems were also taught. Participants found the training in gynaecological skills especially new and exciting. They were full of questions on issues related to reproductive health.

The third phase, held from 27 November to 11 December 1994, focused on enhancing the management skills of trainees, including record-keeping, documentation, planning and maintaining a herbal garden, taking charge of a project with a team and with community involvement. There was also an introduction to action research and participants were asked to develop action plans. Since due to time constraints they could only

Box 6.3

Phase 2 Training

- Women's health care – overview.
- Human body - anatomy and physiology.
- Reproductive system - structure and function.
- Diagnosis and treatment of common ailments.
- Diagnosis and treatment of gynaecological problems.
- Contraception.
- Preparation of herbal medicines.
- Herbal gardening practices.
- Record-keeping and monitoring.
- Health project management.

attempt working at one sample action plan, two three-day follow-up workshops were organised in March and April 1995 to enable participants to formulate these. Survey data collected by the participants in their areas using the action research methods learnt during the training were reviewed and their action plans finalised.

Training Approach

A participatory teaching methodology was adopted throughout the course, the underlying principle being that information given by the resource persons and communication in the classroom should be related to the day-to-day experiences of the women and built on their own realities, so that the knowledge given in the classroom is also useful to them. The communication between the resource persons and the participants was therefore not a one-sided transfer of knowledge but an active exchange of information. The learning process was experiential, rather than based only on lectures and practical sessions, always beginning with participants' own life stories and experiences. The four crucial elements of this approach were thus:

- experience (of participants and resource persons);

- communication (sharing and understanding);
- information (from resource persons, but also often from participants); and
- concentration (implementation and practice).

These elements are essential for the participants to experience empowerment and to use it in the wider social context.

At the personal and group levels, the resource persons facilitated what is called 'psycho-dynamic learning'. Based on an understanding of the psychosomatic processes that affect humans throughout their lives, this approach helps to make the link between how one feels and how one thinks, to internalise new insights, knowledge and experiences, e.g., sharing one's feelings at the end of the day in relation to one's learning and life. By focusing on and internalising certain key feelings or issues, knowledge and experience get integrated into our body, mind and feeling systems. *Dhyana* (meditation) and the ritual of daily 'closure' were used to weave the psycho-dynamic approach into the programme of learning.

An important part of each day's sensitisation and learning process was therefore a short period of *dhyana* in the morning before the learning session began, and the closure at the end of the day. Increased self-esteem and self-confidence was first experienced individually and then explored at the social level. Throughout the course, each participant was guided to consider and answer for herself the questions, *Who am I? Where do I stand in relation to my immediate context?*

The group was led to consider how a person gets a disease. In investigating health concerns, the attempt was always to support the linkage of health with women's lives, and their socio-economic and cultural contexts. For example, during *dhyana* one morning, the group was guided to meditate upon the question: *As a woman, how much care have I taken of my own health?*

The group looked closely at the practical aspects of women's health, including the structure and function of the body, the linkage of physical, emotional and spiritual aspects, and at diagnostic and healing skills. The participants were trained to consider problems according to these

questions: *What can I handle locally in my own setting? To whom should I refer to deal with what I cannot handle?*

The aim of the training was to create self-awareness that would result in attitudinal changes. In order to empower others, one has to first become aware of one's inner boundaries and know how to mobilise one's inner resources. The session on 'Understanding oneself and others' aimed to generate a process of self-awareness among the participants. Through various exercises the trainees were able to get in touch with their own internal resources and energy; in the process, their attitude about themselves and others underwent a change. They could now see very poor and suffering people and women in a new light – not merely as victims of misfortune and oppression, but persons who have untapped inner strength. The group thus discovered the advantages of supporting and releasing internal strengths within themselves and in others.

With yoga, the participants explored the link between the body, mind and emotions. Ill health and discomfort are often partly due to mismanagement of boundaries – interpersonal and environmental. Women were asked to look at the various resources available to them – joy, hope, the capacity to forgive ourselves and others – and learn to heal oneself and others. The focus was to move from an understanding of self to managing one's role in various settings – individual, family, group and organisational.

Training Evaluation

Each phase concluded with an internal evaluation by the participants. They were provided with a brief questionnaire covering content, methodology, resource persons, assessment of knowledge and skills gained, and the programme's limitations. While participants expressed satisfaction with the course content and felt that it adequately covered the theoretical and practical aspects, they also expressed the need for more practical training in diagnosis and treatment for a greater range of illnesses, preparation of herbal medicines for these, and more knowledge of female and male anatomy and physiology and women's health problems. The participatory teaching approach used by the resource

persons was much appreciated and the use of their own experiences and practical examples as well as group work in small and large groups were found to be very helpful. The resource persons were found to be approachable and accessible, both within and outside the classroom, always willing to answer questions and share their knowledge. The majority evaluated the course venues, classrooms, accommodation and catering facilities positively.

An independent evaluation of the programme carried out by the German Foundation for International Development (DSE) also brought out similar responses from the participants. According to the DSE evaluation, the training had a positive impact on the participants' skills and knowledge. All participants emphasised their increased knowledge about the structure and functioning of the body and the use and preparation of herbal remedies for treating them. The training also boosted their confidence and credibility in the community. Many of the participants said that the training had helped them to overcome inhibitions in talking about sensitive issues related to reproductive health. The management skills acquired during the training enhanced their self-confidence and problem-solving abilities. The heads of the participating NGOs also felt that their staff's knowledge and skills as well as functioning have greatly improved after the training.

Conclusion

A concerted effort was made during the pilot training programme to build upon existing knowledge and practice, specifically in the area of woman-centred health care management. While it cannot be claimed that the training introduced many new concepts, there was certainly an attempt to make new linkages among existing concepts and explore new approaches to integrate gender, management and local health traditions in a holistic way.

A unique feature of the programme was the 'psycho-dynamic' learning process adopted. The participatory teaching methodology and the use of participants' own experiences and practical examples were also very helpful. Besides transferring knowledge, psycho-dynamic learning helped to trigger a process of self-awareness in the participants, bringing about

a shift in attitudes. It not only helped them to look at things in a different way, but also helped them to understand that women's health is interrelated with and affected by gender, socio-economic and political factors. The systematic questioning of how they could use new concepts for their own purpose has made the participants confident about using these concepts in their work. By using this teaching methodology and approach, WAH! has in large measure succeeded in achieving the objectives of its programme in the Southern Region.

*Chapter 7***Training of Health Programme Coordinators, Western Region****WAH! Experience****Pallavi Patel**

The first WAH! training in India was done in Southern India by Aikya, Bangalore for the states of Karnataka and Tamil Nadu during 1994-95. A formal evaluation of the Southern Region pilot WAH! training was positive and encouraging. The pilot training brought forth two major challenges for the WAH! programme. One was the interfacing of traditional health practices with modern medicine and the second was to address the social and political linkages related to women's health and development issues. Based on the experiences of the WAH! pilot training, a curriculum revision workshop was held to discuss the possibility of interface of traditional health with modern medicine (see Preface for more details). After synthesising the experiences of the WAH! pilot programme and the curriculum revision workshop during 1997-98, CHETNA took up the challenge of organising the WAH! training for two states, Gujarat and Rajasthan. Following the participatory approach, the training was planned and executed taking into account the concerns expressed during the pilot project, namely, duration of training, method of selecting participants, integration of the gender component in training, etc. Involving trainers of the Southern Region in planning the training programme for the Western

Region greatly enriched the learning in terms of knowledge and training methodology. For example, elements of the Southern Region's 'psychodynamic learning' were brought into the Western Region WAH!

Perspective

While training is a process, it is usually treated as an event. This does not eventually serve to fulfill the training's objective of transformation. Realising this fact, WAH! Western Region adhered to the strong foundation of basic values and sound perspective evolved by the WAH! Core Group. As mentioned in the Preface, the WAH! process was initiated by developing a perspective and documenting it in the form of an approach paper. The WAH! Core Group had also developed a holistic definition of health, which was followed by the Western Region:

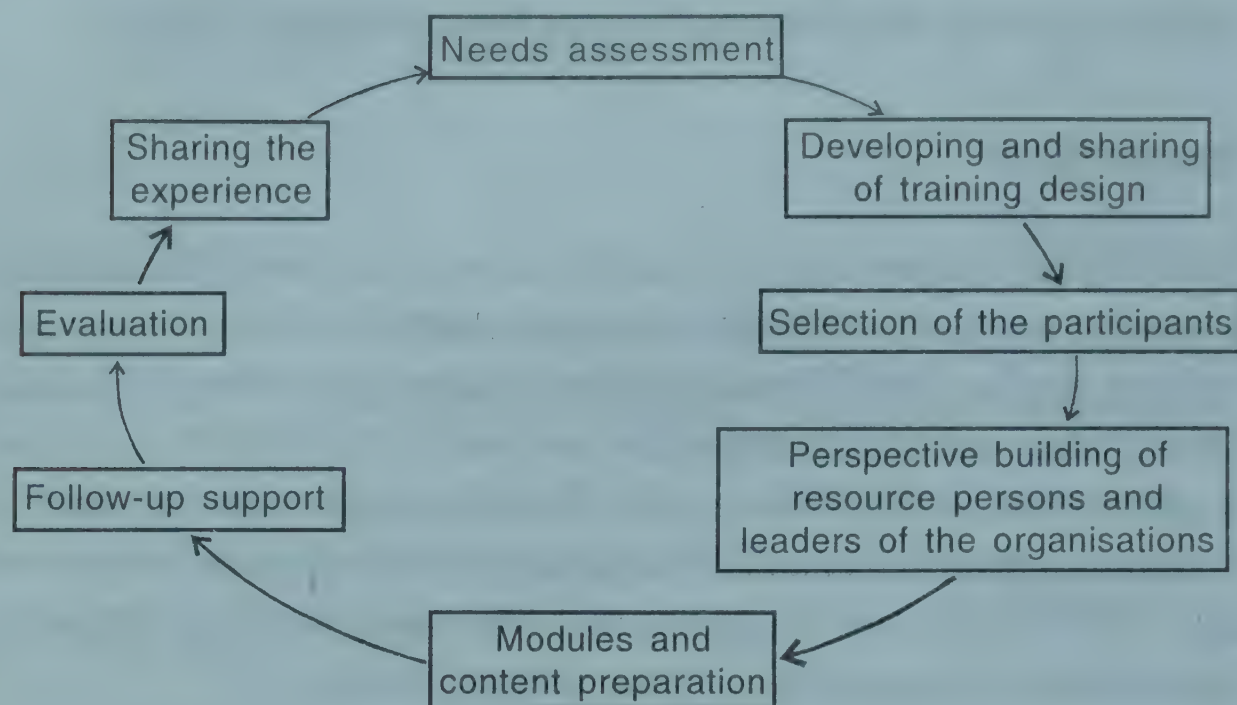
'Health is a personal and social state of balance and well being in which the woman feels strong, active, creative, wise and worthwhile; where her body's vital power of functioning and healing is intact; where her diverse capacities and rhythms are valued; where she may decide and choose, express herself and move about freely.'

A cyclic process was adopted to facilitate the Western Region WAH! Training (see Figure 7.1).

Preparatory Process

Needs assessment: Potential NGO partners were identified from among NGO development projects in the region, women's and health advocacy groups and collectives, government-supported autonomous programmes, etc. Further criteria for selection included an avowed interest in primary health care at the community level, and some experience in community health and social action. The organisations were also required to be prepared for collaboration and ready to send two team members for long-term training, with a view to implementing the learning at the field level.

Figure 7.1
Three Phase Training



Once the NGOs were selected, meetings with them were organised to determine the training needs of supervisory level functionaries. The supervisory cadre in NGOs plays significant multiple roles at the organisational level. Apart from implementing the health programme at the grassroots level, they also act as trainers and supervisors of health activities. However, they usually have a limited role in developing and planning the programme. The existing status of the supervisors indicated that though involved in the management functions of the programme, they had not undergone any formal training. There were also substantial gaps in their knowledge of women's health issues. The need for training and training material at the local level was therefore critical.

Developing and sharing of the training design: Based on the training needs of the supervisors, a three-phase training programme was developed, with each phase comprising 30 days. WAH! envisaged the training to be an empowerment process which would

- enhance the participants' self-esteem, self-confidence and capacity to optimally realise their talents;
- improve their command over health work planning, administration and health work training, including empowerment skills;

- help them cultivate professional and organisational health care standards;
- help them make linkages with health advocacy and network initiatives.

It was expected that the training would facilitate change to occur at the personal, organisational and community levels. A meeting was therefore called to share the design with potential resource persons and leaders of partner NGOs, and the suggestions made by them were incorporated into the design.

Selection of WAH! participants: Participants were selected based on criteria laid down by the WAH! Core Group: a minimum of eight years' schooling, a minimum of three years' field experience and a long-term commitment to the organisation for which they were working. Also required was some indication of the candidates' aptitude for health management and team building in their organisations. Various strategies, such as questionnaires and interviews, were used to ensure the selection of appropriate candidates.

Orientation of the partner organisation and resource persons: While recognising that inputs from external resource persons were essential, it was felt that it was critical to orient these resource persons in terms of the WAH! perspective. It was also felt that since most leaders of organisations were male, it was important that they be sensitised to the WAH! perspective, which would bind them to the women's health movement and provide support to the WAH! graduates in implementing their learning at the organisational level. Special efforts were therefore made to hold orientation meetings for NGO leaders.

Training

The WAH! training module aimed to help participants gain a holistic perspective on women's health. WAH! used the life cycle approach to women's health, wherein health issues from birth to old age were addressed. This approach also took into account the influence of socio-cultural factors on women's health. Gender and its relationship to women's health thus formed an important component and was included in the entire training module. The WAH! training also addressed Traditional Health

Practices (THP) as a tool for women's empowerment, whereby they could take control of their own and their community's health. During each session, reference material developed in local languages and keeping in view the gender perspective, was distributed.

The training was divided into three phases. The initial phase was devoted to perspective building, including sub-modules on the general health situation (analysed through a WAH! perspective), gender and health, traditional health and healing practices, and programme management.

The second phase addressed participants' need for technical knowledge. The topics covered were understanding what is meant by 'sustaining health', gender and health, body structure and functions, epidemiology, understanding diagnosis, concerns of early childhood, adolescent health and development and health concerns of adult women. Efforts were also made to discuss topics such as violence and women's health and the emotional and mental health of women. Each topic was addressed from a gender perspective. An attempt was also made to integrate modern medicine with traditional health and healing practices, and to some extent WAH! succeeded in integrating the two streams. The challenge now is to develop guidelines to effectively implement this at the grassroots level.

The last phase focused on building participants' skills in the area of management and training. The topics included were report writing and documentation, developing training skills and developing management skills. The participants were provided practice sessions for skill building within the classroom and in rural settings.

Follow-up: At the end of each phase, participants developed specific action plans and presented them to the group in the presence of the leader of their respective organisations. At the beginning of each subsequent phase, the experiences of the action plan were discussed at length. In between the phases, the training organisation provided follow-up support to facilitate the process of implementing the learning at the field level (the support was extended for one year after the final phase of training). This was done through visits to the concerned NGOs, helping them in the planning and implementation of the women's health programme, and linking them with other like-minded organisations. Support was also

provided in terms of technical information, data on existing government programmes, and information on the changes taking place in the health scenario at the national and global levels. In addition, special follow-up meetings were organised as and when needed by the participants. Some of these special meetings were also used to discuss participants' role in influencing government health programmes.

In order to understand the gender impact of the WAH! training at the self, family and organisational levels, a post-training evaluation was done by sending a questionnaire to the participants. The questionnaire covered the following areas: Gender Division of Labour, Nutrition, Sexuality, Violence, Mobility and Economic Empowerment, and questioned participants' awareness of attitudes towards behaviour and practices with respect to the gender issues addressed in the programme. The opinions, feelings and comments received from the participants (see Box 7.1) indicated that a change in gender relations at the personal, organisational and community levels had been indeed initiated.

Box 7.1

Some Responses Received from Participants

- My mother-in-law was not convinced that men could work in the house. After the second phase of WAH!, her resistance started to reduce and I could see that she was gradually accepting the idea and opening up. I convinced her that times were changing.
- I have discussed with my husband his role and responsibilities in household work. I have also given him the reference material on gender that was provided to me during the training. Now he is more understanding about the concept of gender. I was very afraid when I first gave him this material, but my fear has gone because he understands the concept and is convinced. He has started help me in household work

Evaluation

The evaluation of the training in the Western Region gave resource persons, trainers, NGO partners and participants the opportunity to reflect on their efforts. It was encouraging to observe that they viewed WAH! training as a collective, long-term endeavour rather than merely a short-

term training effort. However, the challenge of effectively interfacing traditional with modern medicine at the field level still remains.

What the Participants Learned

As mentioned earlier, the WAH! training was a process of empowerment and therefore the cycle of learning went from self, to family, to organisation, to community. Understanding the WAH! perspective provided them the opportunity to reflect on their way of life. The participants realised the difference between what they learnt during the training and their own social values. Though the differences did initially lead to frustration, these ultimately helped them to accept and internalise a gender sensitive way of looking at women's health. When the participants shared their frustrations during the training, the trainers provided them with the necessary moral support and helped them to take the learning forward. On request, special gender training was also organised for family members. Such interventions provided a supportive and enabling environment for participants to put their learning into action.

After strengthening themselves at the self and family levels, the participants could tackle difficulties at the organisational and community levels more effectively. The programme evaluation clearly reflected the social transformation of the participants, and influence at the organisational and programme level. Most participants spoke of the increase in their self-confidence and ability to take decisions, improved health knowledge, and management and documentation skills.

Strengths of WAH!

- Its holistic perspective.
- Commitment of the network to work towards women's health and development concerns and readiness to take the process ahead.
- Openness to work in diverse settings and at the same time maintain its identity.
- Ability to develop a holistic training module with a regional perspective and in the local language.

- Flexibility to offer the training module as per the needs of the participants.

Concerns

Process versus content: Since empowerment was one of the main goals of the WAH! training, the training process itself was given importance. In such a situation, it is likely that the scientific or technical content may get diluted.

Focus on gender versus content: Since health is a technical subject, it needs special emphasis during training. On the other hand, since gender is pervasive in all aspects of life, it cuts close to the bone. Any interlinking of gender with a technical subject like health could lead to the former overshadowing the latter.

Interface of indigenous health practices and modern medicine: Interfacing indigenous health practices with modern medicine poses a great challenge for WAH! It requires tremendous effort to bring together experts of both streams on a common platform to discuss each other's strengths and limitations and to arrive at clear-cut guidelines for programme implementers.

Mainstreaming of WAH! efforts: The unique experience of WAH! training has been appreciated by both NGOs and GOs. Consequently, it has created further demand for training, which a single organisation may not find very easy to fulfill. Mainstreaming is therefore important.

Recommendations

On the basis of learnings from WAH!, certain recommendations can be made with respect to women's health training. Some of these are:

- Any training needs a firm base of clearly articulated perspective, which later becomes a reference point throughout the training.
- Women's health training needs to be addressed comprehensively. Focusing only on reproductive health may not serve the purpose of empowering women. This can be done by using the life cycle approach that integrates a gender and traditional health and healing

perspective.

- Participation by learners, trainers and the participating organisations in the development and implementation of the training is critical to ensure its effective implementation at the field level.
- Training should be viewed as a process rather than a one-time event. Long-term follow-up support is critical for any training to be successful.
- A proper selection of organisations and participants is crucial. Incorrect selection can lead to waste of time and energy.
- Involvement of NGO leaders is important, as it helps in building their perspective and also provides them a platform to discuss how best to interweave the learning of their team members at the organisational level.
- In order to bring about change, training needs to be supported by networking with like-minded individuals and organisations to address concerns at the policy level.

*Chapter 8***Training of Health Programme
Coordinators****Maharashtra WAH!**

Samata Sen-Gupta

The Women and Health Programme in Maharashtra (MAHWAH!) was the third regional training and advocacy initiative in India. The programme aimed at promoting comprehensive, gender-sensitive and sustainable health care for all, with special concern for women and girl children and other deprived groups throughout their different life stages. It approached its goals through:

- Training for building the capacities of health work coordinators.
- Advocacy for bringing policy changes at regional and national levels.

Launched in early 1998, the MAHWAH! programme completed its training programme in April 2000. Twenty-six middle-level workers from 18 NGOs in 11 districts of Maharashtra were trained during the programme. As a consequence of this intensive process, participating NGOs have formed an indigenous forum for interacting with and supporting each other on health issues of common concern.

The Maharashtra WAH! started as a partnership between three organisations or groups: MASUM, which comprised the Training Unit;

Pragati Foundation, which served as the Financial Management Unit; and Mira Sadgopal and colleagues (who later evolved into an organisation called Tathapi), who formed the Documentation Unit (Boxes 8.1 and 8.2 give details of MASUM's Health Programme). In order to broaden the perspectives and expertise, and optimise the efforts of these three units, the need for conducting periodic discussions, reviews and evaluations of the team was felt. A WAH! Core Group member was requested to conduct these inter-team review meetings.

During the course of the MAHWAH! programme, three inter-team review meetings were held in Pune. The main objectives of these were:

- to ensure the development of each unit in terms of expansion of vision and consolidation of values;
- to clarify the roles of each unit and spell out coordination issues;
- to reduce boundaries between the primary functions of the three teams;
- to visualise the units' work and improve inter-unit communication;
- to address some issues of finance and accounting.

The Preparatory Year

During the preparatory year, many discussions to locate the MAHWAH! programme within a broad, progressive and pro-people perspective were held. The MAHWAH! network linked up with various NGOs to discuss their relationship with the state, the challenges of globalisation and the pressures for privatising health care. Many persons involved in supporting the MAHWAH! programme were concerned about how and where WAH! would fit into the emerging political scenario that is characterised by serious disinvestments by the state and powerful incursions by the private sector.

To meet these challenges, it was necessary for MAHWAH! to gain clarity on its own perspective. A workshop for Resource Persons was therefore organised in Pune on October 28-29, 1998. Participants included NGO heads, health professionals, feminists, health activists and those with

Box 8.1**MASUM's Women's Health Programme
Streewadi Arogya Kendra
Feminist Health Centre (FHC)**

Established in 1994, the Streewadi Arogya Kendra (literally meaning feminist health centre) provides space for women to define their own physical, mental, sexual and reproductive health problems. Located at Saswad, the taluka headquarters of Purandar, the centre is routinely accessed by women from the villages of Purandar taluka as well as the town of Saswad.

At the centre, two trained nurses provide basic health care, maternal health care, antenatal services and nutrition education to women. They enable women to identify high-risk pregnancies and take necessary precautions. Reproductive tract complications and infections (RTIs) are also identified and women are encouraged to initiate a dialogue with their partners about sexual health.

This year, 1531 women approached the FHC with illnesses ranging from general health problems like diarrhoea, weakness, backache, piles and arthritis to gynaecological problems like vaginitis, white discharge, pelvic disorders, irregular or excessive bleeding, uterine/bladder prolapse and mental health problems such as depression, mainly due to violence, neglect and abuse.

Women are treated with a combination of allopathic medicines from the Lok Seva Aushadhalaya, herbal remedies prepared by the health team, pertinent exercises and dietary regulation. In addition, health education and encouragement to understand one's body and bodily processes is provided.

The centre also identifies women in violent situations who come seeking health services and refers them to Samvaad, MASUM's counselling centre, which is also located in the same premises.

Women who require surgery or long-term treatment are referred to the Sassoon general hospital in Pune. These women are oriented to understand the functioning of a large hospital and counselled about drug compliance and the importance of completing treatment.

The FHC at Saswad is also implementing a health outreach programme in four slum areas, namely Satthe Nagar, Indira Nagar, Ramoshiwada and Khandobacha Mala. The focus of this outreach programme is to create awareness related to women's health in the community. Regular health education sessions on common ailments, sanitation, safe drinking water and personal hygiene are conducted in the community. Pregnant women and young mothers are immunised and given information about antenatal care and nutrition during pregnancy. The nurses also provide diagnostic services and treatment for common ailments. Regular check-ups of the pregnant women are conducted and they are motivated to avail of the ANC services provided at the rural

hospital in Saswad. Counselling services are also provided for childless couples. Visits to individual households are made to provide counselling services and to follow up those who have already been given treatment. The health problems of 419 women were addressed through the outreach programme this year.

Source: MASUM Annual Report 2001.

Box 8.2

Sadaphuli Kendra

Village-based Health Centre

The *Sadaphuli* (literally meaning ever-blossoming or *Vinca rosea*) centres are village-level women's health centres, which were initiated in 1995. Located in four villages, the centres are frequently accessed even by women residing in the neighbouring villages and hamlets. Their primary focus is to enable women to understand their own bodies and help them to participate in the process of diagnosis and treatment using self-help techniques.

Trained to conduct breast examinations as well as speculum and bi-manual examinations for detection of RTIs and other gynecological problems in women, the *Sadaphulis* (women health-workers at the village level) offer services that are rarely available in villages.

Many women, who have not had an opportunity to seek treatment for chronic reproductive and other ailments, come to heal themselves at the centre, which also provides them with space to express their fears and feelings openly.

This year people approached the centres with a wide range of ailments, including cold, cough, fever, skin problems, piles, bodyaches, headaches, weakness, toothaches, wounds, indigestion, acidity, arthritis and gynaecological problems like infections, sexually transmitted diseases (STDs), uterine prolapse, bladder prolapse, menstrual problems, heavy bleeding, breast lumps, and so on. Of the 3,455 people who visited the various centres to seek health care and guidance, 2,334 were women. While 2,704 of the people visiting the centres complained of general health problems, 551 came for treatment of gynaecological problems.

The *Sadaphulis* treat women with traditional herbal remedies available in the neighbourhood, allopathic drugs under their generic names, acupressure techniques, dietary innovations and exercises. Women with RTIs/STDs are counselled and motivated to initiate a dialogue with their partners to use condoms and obtain treatment if necessary. Herbal remedies from locally available medicinal plants like *neem malam* (neem ointment), *amrutdhara* (pain reliever for cold-related aches), *triphala churn* (used for constipation, as well as in cases of Vitamin C deficiency), *dhotryache tel* (*dhatūra* leaves extract in oil which is used for joint aches), *raal malam* which is used for skin problems,

burns and piles, and *aghadashar* (for toothaches) were prepared by MASUM's health team in small batches throughout the year.

During the course of their work, the *Sadaphulis* realised that a large number of women were suffering from uterine prolapse. A study was conducted to understand the causes for this. Since most women approached the centre only when the prolapse had reached the third stage, when the only option left is surgery, it was felt that awareness on early treatment was essential. Work on a flip-book was initiated to help raise awareness about prolapse. Prolapse was also discussed during health meetings. As a result it is expected that the number of women approaching the centre for prolapse will increase significantly. A large number of women have been motivated to seek medical interventions and have been taken to the government hospital for surgery that is both affordable and without complications. In turn, these women have encouraged their friends, relatives and neighbours with similar problems to seek services. A growing number of women are now becoming aware that there is an alternative to the pain and discomfort of prolapse and have started approaching the centre for treatment.

The *Sadaphulis* have also been involved in raising awareness about various health problems in the community. Health meetings, which are conducted regularly in the villages, focus on prolapse and HIV-AIDS, as these are major concerns in the community. Work regarding prolapse focuses on understanding the symptoms and early seeking of treatment; where AIDS is concerned, the focus is on dispelling myths, creating awareness about HIV transmission and initiating a dialogue around sexuality.

Source: MASUM Annual Report 2001.

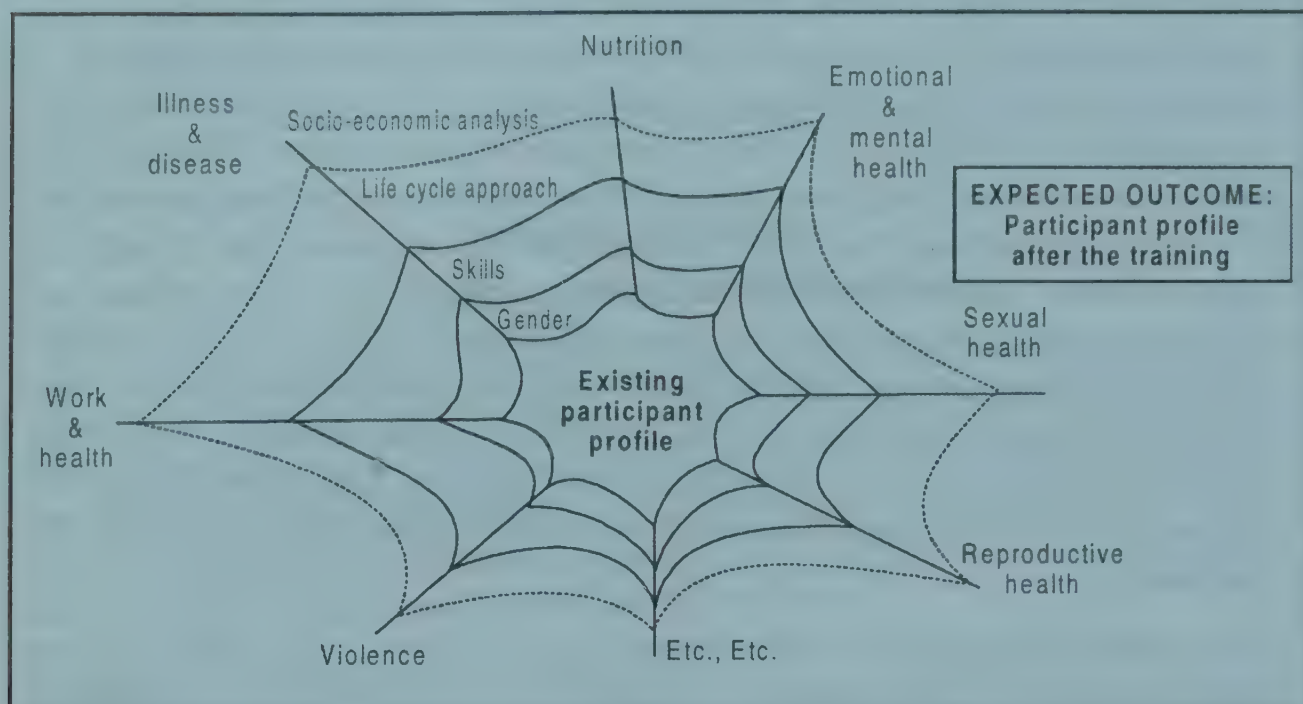
experience in research, training, management and documentation in the field of health.

This workshop familiarised participants with the experience of earlier WAH! programmes. The resource persons were also involved in the specific tasks of planning and implementation of the programme in Maharashtra, and helped in clarifying conceptual and logistical issues, including training goals and relationship with NGO partners (see Box 8.3 for the Conceptual Location of MAHWAH!).

The Web model (see Fig. 8.1), which was developed during the resource persons' workshop, played an important role in clarifying the programme's perspective in Maharashtra. The diagram presents the training process, the profile of the potential WAH! participant and where the trainees are

expected to reach after the three phases of training.

Figure 8.1
The WEB Model of WAH! Training



The central area indicates where the participant is located before the training. The area beyond the outer dotted line represents the expected outcome at the end of the training. Topical areas like nutrition, violence, emotional health, communicable diseases, reproductive health, etc., are shown as different axes of the web. The various threads spanning all the axes represent common processes — such as socio-political and gender analysis, life cycle concerns and skill building — that run through every module and session. Skills to be developed are multifold and include organisational, communication, advocacy and documentation skills.

The model is flexible and serves mainly as a guideline for analysis to ensure that nothing relevant has been missed out.

Selection of Partner Organisations

A lot of thought was given to the process for identifying potential partner NGOs. Criteria for selection of suitable MAHWAH! partners were drawn up, with emphasis placed on long-term, equal partnership that would

Box 8.3**Conceptual Location of MAHWAH!**

- MAHWAH! located 'gender' in the broad framework of class and caste in our society. The socio-economic determinants of health became the basis for understanding gender-related oppression and, in turn, gender sensitivity added to our world-view of society and politics. 'Gender' therefore was integrated in each and every module and session.
- MAHWAH! went beyond the limited reproductive health paradigm, taking into account all situations and needs of women over their lifetime. It also went beyond the 'life cycle' approach by understanding women's lives in relation to caste, class, religion, geographical diversity and occupation.
- It was decided that primary health care (PHC) as an approach would be taken up and developed from both the socio-economic and gender perspectives – including the 'politics' of health and illness. The PHC delivery system was explored in greater detail and reflected in the training and advocacy efforts.
- Traditional Health and Healing Practices (THHP) is an area of training that has been of fundamental importance to the WAH! Programme. It represented one of the three initially divergent streams that WAH! brought together – namely, feminism, traditional medicines, and management. The THHP curriculum of MAHWAH! borrowed from grassroots approaches and feminist initiatives rather than from Ayurvedic Vaidyas. The intention was to allow space for a feminist critique of patriarchy in the Indigenous Systems of Medicines (ISMs) and go beyond the individual-based models by understanding community health. The approach was people-friendly and women-centered.
- It forged a strong link between economics and health.

extend beyond training to include advocacy initiatives on issues of women and health. NGOs that had a fixed ideological agenda of their own were avoided; rather, the focus was on field organisations with an open, dynamic, democratic and pro-women approach and commitment, which were willing to take a fresh look at women and health-related issues.

The main selection criteria included the following aspects:

- Candidates with a minimum of eight years of schooling, preferably having completed Class XII.

- At least three years of experience in health and/or women's development programmes.
- Work experience in at least 10 villages.
- Ability to send two female and one male participant.
- Organisational sustainability of the health programme.
- Mature candidates with team-building skills and aptitude for health management.
- Trainees from diverse backgrounds in terms of caste, religion, cultural background and geographical location (rural, urban and tribal).

Around 150 NGOs from five major geographical regions of the state were sent a contact letter and a questionnaire eliciting their needs and information about their objectives, infrastructure and activities. A total of 60 NGOs responded, expressing a positive interest to participate in the WAH! programme.

Visiting Potential NGO Partners

The process of building partnership with 18 NGOs in 11 districts of Maharashtra began in April 1998. Field visits to potential NGO partners were made to assess the situation at the organisational and field level, get a feel of the NGO's outreach and nature of work, and establish a long-term relationship.

Candidates were selected based on at least one visit to the concerned NGO and after meetings with the suggested candidate at her/his place of work as well as at home. In NGOs where, for some reason or other, it was not possible to meet the candidate, detailed discussions were held with the respective NGO heads. The visits enabled the team to make a preliminary evaluation of the proposed candidates. Special care was taken to ascertain their reading and writing skills. The team also tried to gauge whether the candidates had appropriate family support, as they would have to stay away from home for at least three months.

An initial needs assessment was also done during these contact visits. Since MAHWAH's aim was to register 35 trainees for Phase I, about 40

candidates were tentatively identified, leaving room for a few dropouts.

Needs Assessment of Training Candidates

Prior to the Phase I training, an in-depth, two-day orientation workshop was conducted in Pune to determine the candidates' interests, expectations, abilities and limitations, and assess their training needs. The needs expressed by the NGO heads and candidates from the organisations that had been selected can be broadly categorised as

- Conceptual clarity: perspective building on 'women and health' gender, class and caste issues; economic changes and the socio-political scenario related to health.
- Financial: funding and how to achieve self-reliance; programme budgeting.
- Administration: coordination of human resources, materials and time management.
- Education and training: planning health education; training health-workers.
- Team development: building self-confidence; sustaining staff interest and initiative;
- Community outreach: how to handle issues, resolve conflicts, analyse situations, and create linkages with traditional practitioners.

The NGO heads emphasised the need for strengthening skill-building inputs throughout the training.

In addition, NGO heads also listed numerous ways in which their organisations could contribute to support the training process. NGO partners working in the area of 'women and health' offered resource persons to help in the training. Other areas where NGO heads were willing to contribute their expertise included herbal medicines, first aid, adolescent health, self-help groups, income generation, and communication and media.

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Planning and Developing the Training Curriculum

Based on the needs assessment of the NGOs and prospective candidates, a training curriculum was developed by the training unit. The modules for the Western and Southern Regions were reviewed and suggestions from the resource persons' workshop were incorporated in designing the training phases and modules.

The programme was planned to take place in three successive phases of 30 days each, with a gap of about three months between each phase. Before working on the broad areas of the training curriculum, feedback was elicited from resource persons on the process of developing such a curriculum, stressing the need for a systematic methodology. The steps followed were:

- outlining the objectives of the training;
- visualising the roles programme staff could play in the future;
- analysing tasks (difficult, important and frequent);
- pinpointing the Knowledge, Skill and Attitude (KSA) levels needed and already existing in the candidates;
- calculating total training needs by subtracting existing KSA from needed KSA;
- analysis of total training needs into optimum level of information, development of positive attitudes and skills;
- division into distance and contact training modules;
- clear learning objectives and specific content for each module.

The curriculum itself focused on:

1. Issues related to women's health wherein one could locate health status and access to health care in the broader context of society, polity, economy and culture.
2. Developing technically competent as well as gender-sensitive modules, which encompassed openness towards pluralistic systems of health care and were sound in their perspectives of class and caste.
3. Skill building to ensure sustainability of the training inputs.

4. Practical inputs in each phase, with a gradual increase in skill building sessions in successive phases. The first phase emphasised perspective and attitude building while the following phases focused on practical coordination skills.
5. Integration of modules was ensured to enable the trainees to understand inter-linkages of health with broader socio-cultural and political issues.

Based on the web model, the focus areas for the training were as follows:

- Health and Disease
- Determinants of Health
- Rights and Health
- Coordination skills

Sessions on these four focus areas were planned for each training phase. First, the objectives of each phase were specified, then the modular objectives were spelt out, and finally, the learning objectives of each session, its content and the training methods to be used were decided. A draft of these modules was circulated for feedback to the rest of the MAHWAH! team and some local resource persons who had experience and expertise in the area of women and health. The feedback was shared with the resource person for each session and included inputs on resource materials, training aids and evaluation indicators, and pre- and post-training questions.

The 'level' and impact of each module was monitored by obtaining continuous feedback from the trainees and through the ongoing pre- and post-KAPS tests. If necessary, the sessions were altered based on the responses received.

Training

The MAHWAH! training was conducted in three phases comprising eleven modules. In the NGO context, inter-phase follow-up homework assignments also formed an important part of the training programme (see Annexure 8.1).

Apart from the classroom lecture method, the participatory methodology was used extensively throughout the three phases. This included role plays, simulations, case studies, films and slide shows, games, story-telling, debates, quizzes, panel discussions, demonstrations, yoga, aerobics, field visits, small workshops and so on. Techniques like psycho-dynamic learning, laughter, visualisation and dance were also used during some sessions.

Women and men both have equal roles to play in bringing about gender and social equity in health care. The dynamics introduced by the presence of a small group of men among the trainees enhanced the training process, especially with regard to gender sensitisation.

The MAHWAH! also conducted a separate module on sexual health. For this module, the trainees were divided into two separate groups of men and women. This was done to encourage them to talk openly about their personal experiences as well as discuss their doubts and fears. The session was also used to dispel commonly held myths about sexual health. Given that not much training has been done for men in this area, particularly from the gender and political perspectives, MAHWAH! was treading new ground with this module.

Each phase included educational field visits related to the topics covered during the phase. These visits helped to give trainees exposure to different organisations and their work, and encouraged the exchange of ideas and experiences (see Annexure for list of educational field visits). In addition, MAHWAH! collaborated with three organisations, i.e., Institute of Health Management at Pachod (IHMP), HALO Medical Foundation and the Academy of Development Science (ADS) for specific training modules. These organisations provided trainees with both theoretical inputs and practical skills. The IHMP has developed a participatory training module in health management, the HALO Medical Foundation specialises in health-worker training and the ADS has expertise in training related to local health traditions, herbal medicines and their preparations and use. All three NGOs have well-established field programmes that provided trainees with a good opportunity to learn and practice their skills in the community.

Various cultural programmes were organised in all three phases, giving trainees a chance to exhibit and share their creative skills. Apart from these get-togethers, sightseeing trips in and around Pune were also arranged. A family day was held in two phases of the training, when relatives were invited to visit the training venue, mingle with the MAHWAH team and also interact with each other. This exchange helped families to become more supportive of the training, thereby strengthening the partnership between the MAHWAH team and its trainees.

Tutorial Sessions

Although small tutorial sessions were part of the training design, these were not very effective. Apart from the fact that these tutorials were voluntary, trainees were often too tired in the evening to attend them. Besides, the trainees needed to study in the evenings to prepare for the KAPS tests that were held every 10 to 12 days.

Homework and Follow-up

Homework between the training phases was given a lot of importance as it ensured continuity between phases and also allowed the trainees to put into practice what they had learned during the phase. While planning homework assignments, care was taken to incorporate the suggestions given by NGO heads, and motivate trainees by encouraging them to undertake homework topics that would feed into their ongoing programmes (see Box 8.4 for topics for homework assignments).

Suggestions that were considered when planning the homework assignments included:

- The homework should allow the trainee to put into practice some of the practical skills he/she learnt during the phase.
- The homework should cover an area of work that the trainee would be able to handle independently after the training.

Trainees from one organisation were thus allotted a common homework assignment so that they could work on it together as a team. Consequently, trainees from the same NGO were given a common grade for the

Box 8.4**Topics for Homework Assignments**

- A study of the government health services in the block/municipality: structure, staffing, services, and the people's viewpoint vis-a-vis availability, accessibility, cost and quality of these services.
- Forms of violence against women generally seen in the community and its impact on women.
- Traditional health practices and remedies for gynaecological and reproductive disorders.
- A study of health providers and health-seeking behaviour for common illnesses and illnesses common in women by using the Venn Diagram.
- Preparing a project proposal - situational analysis, objectives, methodology, strategy, time plan, resource planning and budgeting.

assignment. Although all trainees were encouraged to take equal responsibility for the assignments, this did not always happen. In some cases it was found that only one trainee seemed to have taken the trouble to work on the assignment; the others made little or no effort to complete the homework.

Follow-up Visits

During the period between the phases, field visits were made to all the participating NGOs and the progress on homework assignments was reviewed with the trainees and their NGO heads. These visits helped the MAHWAH! team to interact with and observe the trainees in their own areas of work, continue the process of building up partnership, help the trainees clarify any doubts/practical problems and also provide an impetus for completing the homework. In addition, a workshop was held in Pune, where the trainees with common homework assignments could make presentations and obtain feedback. This interaction was extremely useful as it provided trainees with a platform to exchange ideas and learn how the same topic could be approached from different and innovative viewpoints.

Evaluation

The emphasis throughout the training was on self-development and improvement of one's own performance. To make this process non-threatening, a non-competitive method of testing was designed that evaluated each individual only against her or his own performance over the whole year. Goals were set for each individual separately and progress monitored after each module.

At the end of every phase, each trainee's evaluation and results of the KAPS tests were shared with her/him individually and privately. Feedback on strengths and potential areas of improvement was also provided, thus motivating trainees to better their performance in the next phase.

Simultaneous feedback was given to the respective NGO heads to apprise them of the strengths and weaknesses of their candidates. This helped the NGO heads to understand more clearly the sort of responsibilities their candidates could undertake independently.

Methods of Grading

Knowledge, Attitude, Practice and Skills (KAPS) tests were designed for each module. A baseline KAPS test was conducted at the beginning of each module, followed by a post-module KAPS test. The baseline test, which covered the more general issues related to women and health, was conducted in the orientation workshop prior to the training. It served the dual purpose of assessing the level of trainees' knowledge and also provided an indication of the areas/topics that needed emphasis and in-depth information during the training. The formats for the subsequent KAPS tests were more specific and contained a larger number of questions related to practice and skills.

Much thought went into the formulation of the KAPS questionnaire. The first test revealed that subjective questions were not being answered properly. However, this was due more to the poor writing skills of a large number of trainees than their lack of understanding or awareness. The same questions asked in an objective format were answered correctly. It was important, therefore, to design the questionnaire using innovative techniques such as diagrams, pictures and matching exercises.

Other evaluation indicators, evolved jointly by the WAH! team and NGO heads during the orientation workshop, included:

- ability to make simple diagnosis
- being able to prepare herbal remedies
- keeping systematic accounts
- improved report writing skills
- improved presentation skills
- improved analytical skills
- attitudinal change — thinking on socio-political issues, including caste, class and gender in work settings
- increased ability to interact with the community and mobilise resources
- spirit of cooperation and maturity while working in a team

Advocacy and Training: an Essential Linkage

Training and advocacy in the MAHWAH! programme were envisioned to proceed hand in hand. During the training year 1999-2000, MAHWAH! organised two advocacy workshops. The first was held to obtain feedback for the ongoing training, identify areas of common concern and initiate networking for advocacy. A group of about 60 participants, including government health officials, health activists, trainers, researchers, legal professionals, journalists and NGO partners, attended.

This workshop marked the beginning of an attempt to position the collective concerns of the NGOs in Maharashtra with respect to women and health issues. The theme for the second advocacy workshop, 'Sustainability of the MAHWAH! Efforts', was also evolved here.

The second workshop was conducted just prior to the graduation ceremony in April 2000. Partner NGO heads, a few select resource persons and representatives from funding organisations in Maharashtra were invited to participate. The focus was on long-term advocacy concerns, such as, 'How can the MAHWAH! initiative sustain itself?' The idea of creating a forum of all the participating NGOs that would continue to meet and network even after the MAHWAH! programme

had finished, emerged from this workshop. The forum was envisaged to focus on issues of 'health' concern and lobby to advocate changes in health policy at the state level.

Maharashtra Women-Centred Health Forum

The Maharashtra women-centred health forum, or *Maharashtra Stree Kendrit Arogya Manch* as it is called, of NGOs associated with MAHWAH!, was formed in May 2000. This forum hopes to gradually include other health groups and be entirely self-sufficient in terms of funding. With five quarterly meetings already under its belt, the forum aims to network and raise common health concerns in the state.

ANNEXURE 8.1

MAHWAH! Curriculum: Phases I, II & III

Training Phase I (25 February – 23 March)

<i>Module A (25-2-99 to 4-3-99)</i>	<i>Module B (5-3-99 to 14-3-99)</i>
<ul style="list-style-type: none"> • <i>Women's Status in Society.</i> • <i>Genders Roles and Expectations.</i> • <i>Patriarchy: manifestation and effects.</i> • <i>Life Cycle Approach: strengths/limits.</i> • <i>Health and Disease: Definitions.</i> • <i>Bio-medical model and its limitations.</i> • <i>Epidemiological triangle.</i> • <i>Health Care in India.</i> • <i>Alma Ata Declaration: HFA by Y2K.</i> • <i>Primary health care.</i> • <i>Doctor-centred or health-worker based?</i> • <i>Community Health Approach.</i> • <i>Determinants of Health and Disease.</i> • <i>Factors in health care utilisation: availability, accessibility.</i> • <i>Violence against Women: types, causes, manifestations, effects.</i> • <i>Child nutrition and growth: monitoring.</i> • <i>Malnutrition in children: types, causes, treatment and prevention.</i> 	<ul style="list-style-type: none"> • <i>Nutrition: basis and recipes.</i> • <i>Anaemia: types, causes, signs and symptoms, blood testing, treatment and prevention.</i> • <i>Human body: vital parts and functions.</i> • <i>Tuberculosis: overview, causes, signs and symptoms, treatment and prevention.</i> • <i>Leprosy: overview, treatment and prevention.</i> • <i>Local health traditions.</i> • <i>Principles of Ayurveda.</i> • <i>Population policy and politics.</i> • <i>Communication: planning a Health Education Programme.</i>
	<p><i>Module C (15-3-99 to 23-3-99)</i></p> <ul style="list-style-type: none"> • <i>Introduction to planning.</i> • <i>Achieving goals: constraints, aspirations and objectives.</i> • <i>Community diagnosis: introduction.</i> • <i>Community Data I: sources and types.</i> • <i>Community Data II: analysis and interpretation.</i> • <i>Human body: indigenous and Western constructs.</i> • <i>Body image and body politics.</i> • <i>Traditional beliefs and practices: gender analysis.</i>

Inter-phase I Follow-Up Home-Work Assignments (NGO-wise)

A) Common to all participants:

- Make a study of the government health infrastructure in your taluka or municipality.

B) Elective Activity:

(choose one of four)

- Monitoring child growth and nutrition, identifying and selecting 30 children.
- Drawing a 'Venn Diagram' of the health providers and resources in a village, establishing the various linkages between providers and commonly occurring illnesses.
- Violence against women and its impact on community through 10 case studies.
- Identify and study traditional healers and healing systems related to reproductive/sexual health in your area.

Follow-up Visits

Visits were made each of the partner NGO worksites by MAHWAH!

Inter-Phase I Workshop

A two-day workshop relating to homework assignments was held with trainees at the Indian Institute of Education, Pune.

Training Phase II (25 July – 24 August)**Module D (25-7-99 to 30-7-99)**

- *Mental Health*: Overview, understanding social, economic and cultural factors.
- Commonly occurring mental health problems in communities.
- *Domestic Violence*: causes, types
- Building support systems and safety plan for persons facing violence.
- Training CHWs to identify violence and to provide basic support services.
- *Counselling Techniques*: life-stories, listening, communicating.
- *Participatory Qualitative Research Methods*: Introduction.
- Appraisal techniques.

Module E (31-7-99 to 14-8-99)

- *Reproductive and Sexual Health*: Overview.
- *Reproductive Systems* of male and female.

- *Menstrual Cycle*: Ovulation and conception.
- *Contraception*: Methods & action, effects on health, contraceptive use and abuse.
- *Fertility Awareness Education*: Overview
- *Self-Help Workshop Sessions* (separate for Men & Women Participants)
- *Herbarium*: Preparation and uses
- *Health Communication*: principles and preparing educational materials.
- Health education for children.
- *Communication and coordination skills*.
- Group processes and dynamics.
- Inter-personal and group skills.
- Listening skills.
- Personality: building self-confidence.
- *Leadership and motivational skills*.

Self-help Health Workshop Sessions with Men Only

- Introduction to *sexual health*.
- *Sexuality*: myths, feelings and attitudes towards sex.
- Sexual orientation: construction of 'natural' and 'abnormal'.
- 'Masculinity' and body image.
- *Reproductive behaviour* and partner relationships.
- Reproductive and sexual health disorders: treatment and healing.
- *Safe sex and contraception practices*.

With Women Only

- *Sexual Health and Sexuality*.
- Myths/feelings/attitudes towards sex.
- Sexual orientation, construction of 'normal' and 'abnormal'.
- 'Femininity' and body image.
- *Reproductive behaviour and partner relationships*.
- 'Self-help' and 'Self-exam': concepts.
- Self-exam methods: whole body, breasts, bi-manual and vaginal speculum exams.
- Reproductive/Sexual health disorders.
- *Diagnosis, treatment and healing*.
- *Herbal remedies* for common disorders in women.
- *Safe sex and contraception practices*.

[Return to Common Sessions – Mod E]

Module F (16-8-99 to 24-8-99)

(Entire module was conducted by the IHMP team at Pachod in Aurangabad Dt.)

- Introduction to *Maternal Health*: care during pregnancy, childbirth and after-care; risk factors.
- *Immunisation*: Universal Immunisation Programme, vaccine regimens, follow-up.

- *Programme planning*: introduction.
- Planning: definition, need for planning.
- Community analysis and diagnosis: practice.
- Developing a programme plan: selection of feasible interventions.
- Goal and objective setting.
- Workload estimation.
- *Logistical Frame Analysis (LFA)*.

Inter-Phase II: Follow-up Homework Assignments (NGO-wise)

This time the homework was to draw up a detailed LFA (log frame analysis) Chart as practice for the trainees and to aid the partner NGOs in planning for their respective health programmes.

Region-wise Interphase II Workshops:

Region-wise visits were made to meet the trainees who gathered at *five nodal partner NGOs*. There the MAHWAH! teams conducted follow-up 'documentation' mini-workshops to practice recording of process and impact and report writing skills. They also checked on the LFA homework and helped with the project proposals of some.

Training Phase III (18 November – 17 December)

Module G (18-11-99 to 25-11-99)	<ul style="list-style-type: none"> • Homeopathy: overview • Unani system: overview • Dance as a healing method. <p>Training venue shifted to ADS, Kashele for the Local Health Traditions module (11-12/12)</p>
<ul style="list-style-type: none"> • Reservation for Women in Panchayati Raj. • (Homework Feedback: LFA). • Planning of resources: human, material and financial – LFA process extension. • Preparation of budgets. • Supervision and monitoring: Gnat Chart. • Managing programme information and data. • Evaluation methodology. • Process documentation: observation, news reporting, taking minutes at meetings. 	<p>Joined by 3 Bhil health-workers of Jansewa Mandal, Nandurbar.</p> <ul style="list-style-type: none"> • LHT: types of practices, importance; differentiating from 'blind faith'. • Herbal medicines: preparation and uses. • Medicinal plants: identification in forest, nursery and propagation techniques.
Module H (26-11-99 to 30-11-99)	Module K (13-12-99 to 18-12-99)
<p>[This whole module was taken conducted by the HALO team members at Andur in Osmanabad District]</p> <ul style="list-style-type: none"> • Training Community Health-workers. (guide to 'Arogya sathi' training) 	<ul style="list-style-type: none"> • Water issues : availability, distribution. • Water technology: drinking and sanitation. • Street Play workshop : drama exercises. [Visit to MASUM.14/12: Health work in context of SHG Savings & Credit work.] • Legal rights of Women. • Funders' panel: how to obtain financial assistance for health programmes. • Feedback from NGO heads, phase closing, follow-up planning, homework and evaluation.
Module I (2-12-99 to 7-12-99)	
<ul style="list-style-type: none"> • Practical : Training of Trainers (TOT). • Making and using puppets. 	
Module J (8-12-99 to 11-12-99)	
<ul style="list-style-type: none"> • 'Alternative' healing systems • Ayurvedic massage (4 morning sessions): introduction, demonstrations 	

Post-Phase III Follow-up

Homework assignment and region-wise NGO visits:
Each of the trainees had to plan and conduct a training session in her or his field area consistent with the NGO's health project plans.
The MAHWAH! team members coordinated their visits with these sessions.

Educational Field Visits**Training Phase I :**

- Katraj Snake Park: Snakes varieties were identified; trainees learned about snakebite prevention and treatment.

Training Phase II

- Medical Plants Nursery: About 150 varieties were identified from garden and herbarium sheets.
- (Men's group) Indian Health Organisation situated in the red-light area of Pune working on issues of HIV/AIDS.

Training Phase III

- Aalochana Women's Resource Centre.
- Muktangam De-addiction Counselling Centre.
- Nara Samata Manch Women's Shelter.
- Jayakar Library, University of Pune.

Organisational Training Visits

In Phases II and III, the trainees were exposed to the field-based work of four organisations relating to community health and women's development, and training health and development workers.

- Institute of Health Management, Pachod, Paithan Taluka, Aurangabad District.
- HALO Medical Foundation, Andur, Tuljapur Taluka, Osmanabad District,
- Academy of Development Science, Kashele, Karjat Taluka, Raigad District.
- MASUM, Purandhar Taluka, Pune District.

IHMP, HALO and ADS served as outstation host sites for modules F, H & I respectively.

Cultural Performances**March 8 : *International Women's Day***

The trainees put up a variety programme of cultural entertainment at BAIF.

August 2 : *Hoi Mee Savitri !*

Well-known actress Sushma Deshpande performed her one-woman play on the life of Savitribai Phule at BAIF.

August 21: *Variety Event*

Cultural 'thanks' to IHMP Pachod.

November 28 : *Haasya Kallol !*

Mr. Deepak Deshpande of Sholapur gave a humorous performance in many cultural and regional voices at HALO, Andur.

*Chapter 9***Where Women Matter
Training for Women's Health
Reflections from the Field**

Abhijit Das and Jashodhara Dasgupta

Slowly but surely, over the past decade, women's health has been getting the importance and recognition that is due to it. To a great extent, this has been possible due to the international focus on reproductive health (International Conference of Population Development [ICPD] -1994) and women's development (Fourth World Conference on Women [FWCW]-1995). For very long, the health programme in India had been heavily tilted in favour of family planning and this has unfortunately had an adverse impact on women's health and rights. As a consequence, there have been some major changes in India's approach to women's health. Starting from early 1996, a series of policy and programme initiatives have been taken, i.e., the announcement of the Target Free Approach, the Reproductive and Child Health Programme, the Community Needs Assessment Approach and the National Population Policy. Discernible changes are taking place at the ground level – their pace being faster in some places and slower in others. A key factor that has been holding up the pace of change is the deeply entrenched, population-control mindset of the policy planners. Changing this retrogressive mindset is a major challenge of the hour. And training has an important role to

play in meeting this challenge.

Learning from Field-based Experiences

Sahayog is a voluntary organisation working intensively on women's health-related issues in Uttar Pradesh. Health has been a core concern of Sahayog and its team includes both doctors and trained nurses. Though its initial experiences in health were entirely in the Mother and Child Health mode, living and working closely with women made the Sahayog team realise that this approach was not adequate for addressing women's health needs. It was during 1992 that the organisation started to experiment with new approaches to women's health.

Based on its experiences, some of the first lessons that Sahayog learnt about women's health were:

- It was too simplistic to deliver messages even about good diet and antenatal practices without first understanding the complex social system which dictates current health-related behaviour;
- It was not possible to ignore gender relations in society when considering the issue of women's health because they impinged on all aspects of their health – including the kind of morbidities they have to face, when and what sort of health care delivery services they can access, etc.;
- The mother and child approach missed out a whole range of diseases that the Sahayog team had been taught to recognise as gynaecological morbidities.

This was before ICPD. At that time, Sahayog was wholly involved in community-based work in rural Uttaranchal, and had little awareness of what was happening in the world at large. In the course of its field-based work, Sahayog was trying out new models of *dai* or Traditional Birth Attendant (TBA) training, village health-worker training, new communication and awareness generation strategies as well as different ways of mobilising and involving women to care for their own health. It was some time in 1994 that the organisation first heard of the terms

'Reproductive Health' and 'Reproductive Tract Infections' (RTIs). Initially, they were totally confused, because their formal training in medicine had prepared them for Obstetrics and Gynaecology, and they associated the term RTI with Respiratory Tract Infections. It took them a while to reconcile to these new terms and realise that in part, these concepts dealt with the same things that they were concerned about, though in a slightly different way.

And then there was ICPD. In the post-ICPD period, Reproductive and Child Health (RCH), Target Free Approach (TFA) and Community Needs Assessment Approach (CNAA) and all the rest followed. Training programmes for women's health became very popular and Sahayog was soon swamped with requests for training in women's health from different government and para-government sources. Fortunately, Sahayog was able to assimilate the new buzzwords relatively quickly and since they had been experimenting with newer training modules on this aspect earlier, they were in a position to deliver.

Training Experiences

As mentioned earlier, Sahayog had become concerned about the inadequacy of the MCH model by 1992 and was trying out alternative strategies. One of the first activities that they put together with their new thinking was a training programme on Women and Health in June 1993. This training was meant for middle-level workers of voluntary organisations. The training was designed to understand the conceptual underpinnings of how gender, social circumstances, workload and terrain affect women's health in Uttaranchal. It was successful in the sense that it was attended by a large number of participants and they all said they found it interesting. However, Sahayog trainers felt that the training had failed, since it had not taken into consideration the learners' own experiences. They had been discussing factors affecting women's health, not realising that the learners were unfamiliar with even basic concepts of women's health like menstruation, reproductive anatomy, process of conception, etc. They also realised that important concepts like gender and women's health, and social and religious practices needed to be

approached from a practical rather than a theoretical angle. In addition, they understood that while women's development was by and large the most important concern for several voluntary agencies of Uttaranchal, women's health had not yet been looked upon separately.

Sahayog's first training programme was a very important learning experience for the group, because since then, they have struggled to make their workshops on women's health as simple and shorn of theoretical and conceptual inputs as possible. The initial plan was to provide gender sensitisation training to health care providers in the voluntary sector, but they soon came to the conclusion that there were very few such providers. So instead of having training programmes that focused on just gender sensitisation, they evolved a method whereby they could gender-sensitise workers as well as provide the learners with basic skills and knowledge related to women's health. Gender sensitisation and the technical components have thus been interwoven in all their training programmes. The various cadres of health-workers trained by Sahayog include TBAs, village health-workers, middle-level health-workers, trainers and programme managers.

Later, Sahayog got the opportunity of working with government health care providers – Auxiliary Nurse Midwives (ANMs), male workers, medical officers and trainers of medical officers. In these training programmes, it was assumed that the providers were technically competent; the focus was thus on helping them to become more effective and sensitive providers.

Training within the Government

Around the time Sahayog was trying out the new training modules (1996-97), it was invited by a government training institution in Uttar Pradesh (U.P. Administrative Academy) to assist them in developing some modules for Reproductive and Child Health (RCH) for the State Innovation in Family Planning Service Agency (SIFPSA) project (a Family Planning project in U.P. funded by the United States Agency for International Development [USAID]). This provided the Sahayog team with just the opportunity they needed to mainstream their ideas. Since none of the

faculty at the UPAA had much experience in RCH, the team was given a free hand in designing the training curriculum and methodology. They had to do a fine balancing act between giving adequate training time to Family Planning methods (UPAA's priority) and yet have enough time to focus on new ideas in reproductive health like RTIs, abortion, infertility and, of course, gender, reproductive rights and male responsibility. Even though the team demonstrated each level of training at least once, they had prepared elaborate and easy-to-follow training manuals because they did not want to take any chances on how these programmes would be replicated by the in-house faculty. Subsequently, two other quasi-government institutions, Uttarakhand Mahila Dairy Project and Mahila Samakhya, also approached the team to train their staff in women's health.

Sahayog was also keen to intervene in the government machinery, even if only in a small way. While attending block-level Primary Health Centre (PHC) meetings and the district-level medical officer (MO) meetings, the team realised that these could serve as training fora, an idea that the TFA Training Guidelines also suggested. A detailed training needs assessment with the ANMs of three blocks was therefore conducted to identify areas where they could be strengthened. With the permission of the Chief Medical Officer (CMO) of Almora district, the team initiated a programme where they could take a 45-minute session with ANMs during their monthly meeting. While the supervising officers (the CMO in the district and the MO in the PHC) were quite enthusiastic, the intended learner group took this as an unnecessary imposition on their time. The team tried using slides and videos in order to make the training interesting, but after three or four months it was clear that the intended learner group dreaded meeting with the team. The training was therefore stopped. They had the same experience when they worked with medical officers who came for the monthly meeting at the CMO's office.

In August 1999, Sahayog was provided its first opportunity to really train Medical Officers in Reproductive Health and Gender through an intervention of the United Nations Population Fund (UNFPA) in its project in Himachal Pradesh. The outcome of this programme was so successful that UNFPA decided to introduce this kind of gender sensitisation training

in all its six state projects, for which Sahayog was given the charge of designing the training manual. Subsequently, the group was also given the opportunity to train ANMs and male workers, again as a result of UNFPA's initiative in its Haryana project.

Training with NGOs

The organisation's initial experiences in training workers of voluntary organisations in Uttaranchal were not very successful. This was primarily because at that time, two government-sponsored projects, SIFPSA and SWAJAL (Uttar Pradesh Rural Water Supply and Sanitation Project), were funding a large number of voluntary organisations. This affected the autonomy of voluntary organisations to decide their own priorities and programmes. But soon there was a demand for training from NGOs from UP, HP, Bihar and Madhya Pradesh. Sahayog started with short, five-day courses; but it soon realised that the middle-level workers had very little background in and orientation to women's health. The challenge thus lay not just in changing attitudes but in enhancing knowledge and skill bases as well. Keeping this in mind, the team developed a three-phase training programme covering the social and technical aspects of women's health. Each 10-day phase was followed by a three-month period in which the trainees had to complete a back-home task, albeit with field-based, technical assistance and support by the team members. This annual training cycle has been conducted for the last three years and over 25 women's health activists have completed all three phases of the programme.

Key Elements in the Training Programmes

Some of the key elements of Sahayog's women's health training programmes are:

Women-centred training: Concern for gender and its impact on women's health is an underlying theme of the entire training programme. Learners are first asked to analyse their own experiences from a social perspective. For example, when dealing with reproductive anatomy, learners are required to start with differences in the male and female

body, look at the social constructs which highlight these differences, try and analyse if these are necessary and how they affect the self-image of men and women and their position in society. Body-mapping follows to get the learners to accept their own bodies. Similarly, for commonplace topics like antenatal care or childbirth, efforts are made to take on board the extant common practices. Learners are encouraged to analyse these practices from the point of view of the woman – how she feels and how much autonomy she has. Some of the topics that have been included to make the training more women-sensitive/centred are reproductive rights of women and men, male responsibility for promoting women's health, and infertility and its social implications.

Experience-based reflective mode: Sahayog firmly believes that women's health is not a new topic for the learners in the training programmes, who are in any case mostly women. They themselves have gone through the various phases of a woman's life and have their own beliefs and practices. The team is also convinced that the present state of women's health is not just a result of lack of information and adequate services, but a product of beliefs and practices that are very deeply rooted in culture. In order to promote a positive attitude towards women's health it is imperative that the workers themselves examine their own beliefs and myths. Otherwise no amount of messages will have any appreciable effect. Analysis of each aspect is therefore encouraged to understand the prevalent beliefs and practices and the reasons underlying them. This helps the learners understand the causes of morbidities and health-related problems. Thus gender, workload, social position and poverty emerge as major causes instead of lack of hygiene, lack of medicines or prevalence of germs.

Promote appropriate local knowledge/practices: As has been discussed earlier, the initial focus is on understanding the prevalent beliefs, customs and practices in the communities from which the learners come. If the learners are not from rural communities, they are encouraged to share their urban practices. Care is taken not to dismiss these as unscientific or harmful. If the learners decide that some of the practices are either harmless or even useful, care is taken not to disturb them and the useful ones are reinforced. The attempt is to refrain from replacing

prevalent customs with new knowledge without a thorough discussion about the utility of the latter. It is true that there are many harmful practices followed by rural communities, but just condemning them or encouraging the communities to replace them with healthy practices does not produce lasting results. It is equally true that there are some good practices that must be recognised and promoted. One example of this is the birthing position. Rural communities in Uttaranchal adopt a squatting position, which is physiologically better suited for the birth process. Care is therefore taken not to promote the supine or lying down position just because it is practised in hospitals.

No knowledge is value-free: It is commonly believed that scientific knowledge is value-free. Sahayog rejects this position. During the process of analysis and reflection, learners are urged to look at the underlying values which a particular belief or custom promotes. The knowledge or practices promoted during the course of the training are loaded in favour of women, the poor, and client control.

A gender-sensitive attitude is not a replacement for adequate knowledge and skills: While learners are encouraged to share and analyse their own experiences, the Sahayog team is aware that this will not make them competent health care service providers, managers or trainers. So while the emphasis is on creating a women-centred approach, care is taken not to dilute the technical aspects of the training. Detailed learning material has thus been prepared — visual for the not-literate learner and in simple Hindi for those who can read with some felicity. One problem that Sahayog faced was the lack of appropriate learning/training aids in women's health. In this, it has received a great deal of support and inspiration from the material produced by CHETNA — an NGO working on women's health and related issues — which it has freely adapted. Where skill-building is concerned, the Sahayog team has to incorporate as much demonstration and practice as is possible within a training situation and the time constraints it imposes. The team is also very careful about not exposing *dais* to a hospital milieu since a hospital setting is not the setting the *dai* is going to operate in. Furthermore, in the hospital she may learn ideas that might be counterproductive like the supine or lying position, or shouting at and scolding the women in labour.

Training is not a one-time activity: This belief is often difficult to translate into action, because many of the learners are nominated by organisations that do not share this belief. Sahayog tries to keep in touch with the learners through its quarterly newsletter on women's health, and its three-phase training approach ensures follow-up. Sahayog also provides field-level assistance to the learners.

Trainer's role: The trainer's role in such a training model is very critical. Trainers have to be very careful not to be judgmental when the learners share their experiences. They should be able to encourage discussion and analysis without promoting their own point of view. The commitment of the trainers to women, the poor, and to client control must be clearly visible during the training event through their actions. The trainers must be aware of the situation in rural communities. This not only helps them to be sensitive, but also ensures that they have adequate grassroots experience in working with women. Inviting so-called 'expert' guest trainers is not encouraged because Sahayog feels that these experts not only lack the appropriate attitude, but also tend to use tough and technical terminology. Even doctors cannot be considered experts in these trainings, because they often have little or no experience of rural communities or of their social circumstances. In training programmes where the technical and social components have to be finely balanced, this can prove to be disastrous. Sahayog has chosen to emphasise the social component, because it believes that the committed worker will seek knowledge to suit her needs, but the contrary is almost never true. Trainers are therefore encouraged to show no hesitation in acknowledging areas in which they do not possess knowledge; they should be able to tell the learners that they will look up the relevant information and get back to them.

Challenges

The strategic importance of training: Training is a service and like all services, it can only succeed if there is a demand. A positive factor is that training is being included as part of most women's health-related programmes and projects. But the question remains about the intention of these trainings. The people involved in designing and managing the

programmes often remain unconvinced about their usefulness. Gender sensitisation training programmes get included because they are now the 'in thing'. The strategic importance of training is often not understood by programme managers. Sahayog is concerned about the universalisation of trainings as events without the commitment to follow up in terms of programmatic changes and the monitoring of those changes. This is true of both government and non-government programmes.

Assessing the impact of gender training for women's health: One of the most important challenges is to ensure that the training bears fruit in the community, particularly for women, because no training is an end in itself. The Sahayog team has tried to follow up on some of the trainees in their workplace, but this has not been as satisfactory as could be wished. In many large-scale efforts, the number of trainings and trainees still remains the benchmark of assessing the success of training. The traditionally used pre- and post-training evaluation formats are very inadequate to judge the impact of attitudinal training like gender sensitisation. There is therefore a need to develop sensitive and effective indicators for evaluating the impact of training on women's health.

Cooption of terminology: The term 'gender' is getting increasingly coopted and sanitised. It is important to realise that the health of women is affected by the unequal distribution of resources, and their access and control over them. Unequal power relations are manifested in various ways that affect women's health and morbidity, understanding of their own bodies, and their response to illness and health-seeking behaviour. Unfortunately, this analysis is totally absent in the government RCH programmes (including the Mother NGO schemes). An apolitical understanding of gender cannot lead to women achieving greater control over their own health.

Integrating skills, knowledge and attitudinal training for women's health: The increasing concern for quality of care and reproductive health in the mainstream health sector is reflected in the provision of such technical training as that for intra-uterine device (IUD) insertion, laproscopic ligation, counselling, and integrated skill training for RCH. Since the emphasis here is on acquiring knowledge and skills, the trainers need to be technically competent individuals. Unfortunately, the

assumption seems to be that the trainers' skills are already evolved and so there is no need for further training to update them. Unfortunately, this assumption is totally unfounded, because in the course of formal training, health care providers are hardly ever trained in dealing with people in a human way. It is thus essential that attitudinal aspects, especially those pertaining to gender, be incorporated into skill-based training. This will not be possible if trainers of health care providers are restricted to doctors and nurses. Individuals from the NGO sector with experience in gender training and social mobilisation must also be involved in designing and conducting trainings for health care providers. Sahayog has made a small beginning in integrating technical health aspects with social aspects in its holistic training on women's health for middle-level NGO workers, and the results are encouraging.

Population concerns and women's health: The concern for women's health is still somehow related to population control. Provision for training in RCH is the only concession made. Until and unless it is recognised that women's health is important in its own right, training programmes on women's health will pay just lip service to gender and continue with the contraception and family planning agenda.

Training for women's health in the formal health education/training sector: The greatest challenge for training in women's health is the sensitisation of the formally trained health care providers – health-workers and doctors. It is true that a beginning has been made. But though this beginning is significant, it is still very inadequate. Women's health in the medical realm remains confined to the corridors of the gynaecology and obstetrics department. There have been no significant changes in the way doctors and ANMs are taught these disciplines for many, many years. Medical and nursing councils remain totally unaffected by the changes that have taken place in the understanding of women's health worldwide. Textbooks on preventive and social medicines continue to be preoccupied with their model of agent-host-environment, with little or no recognition that the environment includes the socio-cultural environment and the host is not just a biological individual but also a living being with emotional and behavioural aspects that cannot be explained by biology alone. Textbooks in gynaecology and obstetrics remain as technical and

de-humanised as ever. This total lack of understanding of the socio-cultural aspects of health, particularly of women's health, has resulted in the National Institute of Health and Family Welfare preparing tomes on how to train Medical Officers, Health Supervisors and ANMs for the RCH programme without any reference to gender and its implication for women's health.

Conclusion

Training for women's health that makes women its central concern is of crucial importance but unfortunately not enough is being done in that direction. From being a passive mother, women have been elevated to the rank of a 'client', but this has hardly made the health sector sensitive to her health condition and needs. Fortunately, there are small experiments like Sahayog's that are trying to define an alternative paradigm for training in women's health. It remains to be seen, however, whether these experiences are able to develop enough crucial energy to effect sector-wise changes.

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Chapter 10

Clinicians' Training for Gender-Sensitive Reproductive Health

Women-Centred Health Project in Brihanmumbai Municipal Corporation

Renu Khanna, Usha Ubale and Sneha Khandekar

The Women-Centred Health Project (WCHP) is a collaborative venture of the Public Health Department of the Brihanmumbai Municipal Corporation (BMC), Society for Health Alternatives (SAHAJ) — a non-government organisation based in Baroda — and the Royal Tropical Institute (KIT), Amsterdam. The goal of the WCHP is to improve the quality of care provided by BMC, especially in the context of reproductive and health care, from the perspective of women. The objectives of the project have centred around making existing services gender sensitive, and expanding the range of services for women's health available at primary-level health facilities.

WCHP is housed in a BMC building in the western suburbs of Mumbai and is being implemented in two wards of the city (G North and H East), covering a population of approximately 10 lakh. In these wards, both of which have a high proportion of slum population, BMC has 17 health posts, 11 dispensaries, two maternity homes and one hospital. The WCHP works intensively with the health posts and dispensaries and, to a lesser extent, with the maternity homes and hospital. The project is

staffed by seven BMC employees seconded to the project (including the Project Coordinator) and eight other persons employed by the project. A three-person team consisting of the Project Coordinator and two external collaborators is responsible for project management. The specific contribution of the KIT component is technical assistance. SAHAJ contributes to the financial management and organisational development aspects of the project, including the integration of the women-centred perspective. A task force of senior administrators and clinicians from within BMC look after the planning and implementation of WCHP activities.

Here we look at the strategies used to expand the range of services to include the treatment of Sexually Transmitted Infections (STIs) and gynaecological conditions, with a focus on the training of clinicians.

Expanding the Range of Services

The primary health facilities operated by BMC are of two types: dispensaries that treat common ailments of people through daily out-patient clinics, and health posts that were set up under the India Population Programme-V to provide family planning and immunisation services in the community. Both the dispensaries and health posts have not considered women's gynaecological problems and reproductive health as part of their service package. The implications of the lack of gynaecological services at the primary level are many, an important one being that women delay seeking treatment. Talking with women in the course of our work, we found that women treat reproductive tract infections (RTIs) with home remedies. They expressed that they feel uncomfortable about complaining of white discharge in public health facilities. When symptoms become more serious, they approach hospitals. However, the opportunity costs of approaching hospitals are much higher, thus increasing the cost of treatment for the poorest of the poor.

Baseline studies done by WCHP revealed that the two types of facilities, the health post and the dispensary, more often than not existed in the same premises and had the resources, including doctors, that could be reorganised to provide some basic gynaecological services.

As a strategy, the WCHP thought that a committee of health care providers from within the system could spearhead the expansion of women's health services at the health post and dispensary level. A Clinical Sub-Committee was thus set up and comprised of six health post and dispensary doctors from the two project wards, gynaecologists from the two maternity homes, and five consultants and teaching staff from the Lokmanya Tilak Medical College. As a first step, the Clinical Sub-Committee prioritised the following services to be introduced in the first phase:

- Diagnosis and treatment of RTIs;
- Antenatal care (ANC), which is typically provided through Post Partum Centres or Maternity Homes that are the secondary-level health facilities providing specialist care;
- Menstrual disorders; and
- Infertility.

The Sub-Committee members agreed that while it may not be possible to treat infertility and menstrual disorders entirely at the primary care level, it was necessary to train the doctors in the basic management of these conditions so that they could do informed referrals.

Clinicians' Training

Detailed Task Analysis was done to ascertain what was expected of the doctors at the health post and the dispensaries in the treatment of women with any of the conditions listed earlier. Flow charts for the diagnosis and management of RTIs, including sexually transmitted diseases (STDs), to suit the Mumbai context were drawn up, as were protocols for dealing with infertility. A training programme for clinicians in the two wards was designed to

- Upgrade their skills in the diagnosis, management and referral of the four conditions.
- Improve their skills in communication and counselling.
- Sensitise them to gender issues in health.

The training attempted to bring together the clinical and social aspects of women's health through its design and the interdisciplinary trainers' team. The classroom sessions were based on participatory methods, including role-plays and quizzes. They were followed by practical and supervised experience at the teaching hospitals. Detailed documentation of the training for two batches of clinicians was done in the form of a manual, which was supported by reading material on each topic.

The clinicians' training was followed by training for laboratory technicians. Technicians from the six upgraded dispensaries (certain dispensaries called the upgraded dispensaries have diagnostic laboratories attached to them) were provided two days of training on basic investigations for RTIs, like wet smear, gram stain, etc. The technicians' training also included semen examination to rule out low sperm count in infertile couples. Some members of the Clinical Sub-Committee felt that it would be possible to do semen examination at the primary-level facilities. Others thought that while this may be technically possible, in logistical terms it would be difficult to collect semen samples in the health posts or dispensaries, given the lack of space within the Mumbai situation.

As mentioned elsewhere, one session in the clinicians' training was on how the health post and the dispensary could work together to provide woman-centred health care. This session resulted in determining a number of steps that could be followed to bring about better coordination between the two facilities. The clinicians also suggested a monthly meeting as a follow-up to the training and to serve as a forum for continuing medical education. The next step was to work with the clinicians on quality indicators and the recording and reporting system, and to finalise this for presentation to the BMC administrators as well as to pilot test it in the two wards. Box 10.1 gives the details of WCHP's Clinicians' Training.

The clinicians' training was thus designed to integrate social and gender dimensions, communication and counselling skills and clinical content. The training schedule contained discrete sessions on each of the aspects mentioned earlier. In addition to focusing on technical content, each clinical session also incorporated the women's perspective on that particular health condition, gender issues around the particular condition and aspects of communication and counselling necessary for that condition. The

teaching methodology included role-plays for enhancing communication and counselling skills. Four half-days of classroom training was followed by six days of practical training at the gynaecology OPDs of the teaching hospitals conducted under the supervision of the Clinical Sub-Committee members.

Detailed guidelines were given to the trainees as well as the supervisors to ensure maximum utilisation of the field training. Each trainee was expected to handle/manage at least 10 cases each of RTIs, menstrual problems, infertility and women registered for antenatal care. Evaluation of the training included observation of communication and counselling skills and sensitivity to the social and gender aspects. Post-training evaluation showed that the trainees benefited from a handy one-page summary checklist provided for practical experience. This checklist highlighted the clinical as well as social aspects of each of the conditions that needed to be considered during treatment. At the end of the practical training period, the trainees were given feedback based on the observation checklist used by the supervisors.

Evaluation

Pre- and post-training tests were carried out to

- Assess the baseline skills and knowledge required for treatment of common reproductive tract conditions covered in the training programme.
- Assess the effectiveness of the training.
- Identify the weak areas in teaching and learning.
- Identify need for further inputs.

Model answers to the questions were prepared by the members of the Clinical Sub-Committee. The pre- and post-test developed for this purpose included both open-ended and multiple choice questions as well as some case studies. Of the 37 questions, 24 were based only on clinical aspects; the remaining had both clinical and social components. The distribution of marks was slightly biased towards questions on social

Box 10.1

Details of the Clinicians' Training

Goal

The goal of the training programme is to enhance the perspective, knowledge and skills of the clinicians at the health posts and dispensaries for the management of menstrual disorders, leucorrhoea, sexually transmitted infections and infertility at primary care level.

Expected outcomes

At the end of the programme, the clinicians would be able to:

- Diagnose women's reproductive health problems.
- Apply their understanding of the various socio-cultural and gender factors contributing to women's poor health status in the management of reproductive health problems.
- Correctly manage the prioritised reproductive health problems.
- Appropriately communicate with and counsel patients.

Training schedule

On the basis of the expected tasks, an overview of the session objectives, methodology and methods of evaluation was prepared (see Annexure 10.1), followed by session notes. The evaluation of the first training showed that four half-days of training was too short to cover the programme; the time schedule has therefore been extended to cover six half-days.

1. Workshop (6 half-days- 25 hours).
2. Field training (6 days).
3. Feedback session with Trainees and Trainers (2 hours).

Participants

Clinicians working at urban primary care centres in groups of 20-25

Training team

Since the training is based on a multi-disciplinary approach, the training team consists of following persons:

- Workshop Coordinator
- Facilitator
- Clinical Expert
- Expert in Communication and Counselling Skills
- Expert in Gender and Health

Evaluation

The programme was evaluated by the following methods.

1. Evaluation of the participants in the workshop.
2. Evaluation of the training sessions.
3. Evaluation of the field training.
4. Evaluation of the participants during field training.
5. Final evaluation of the participants.

The health post and dispensary doctors also submit a monthly report of the cases seen by them as a part of ongoing monitoring.

aspects, for which 83 marks were assigned. Clinical aspects were only allotted 60 marks.

The tests were administered in the first session of the training and after the classroom and hospital-based practical training.

Result of the Evaluation

Assessment of the pre- and post-tests showed that for Batch I, the overall score improved from 28 per cent in pre-test to 48 per cent in post-test. For Batch II, it improved from 36 per cent in the pre-test to 46 per cent in post-test. In the clinical section, the average score for Batch I was 58 per cent and for Batch II it was 53 per cent. This distribution of marks indicated that the trainees had scored less than satisfactorily in the social aspects. An exploration of the reasons for low scores revealed a number of contributing factors.

The use of case studies to discuss social aspects was a relatively unfamiliar technique for the clinicians. Sessions on gender and counselling included inputs on theoretical aspects, which again were new for most of the participants. This possibly explains the Batch I average of three out of 13 marks for the social aspects of the session on 'gender' and one out of four marks for questions on the counselling session. The fact that the same trainers conducted the training for both batches eliminates the possibility of trainers' bias.

The topics that showed the highest increase after the training were Communication, Leucorrhoea and Referral.

Besides the evaluation of technical knowledge, shifts in attitudes and skills gained were assessed through the role-plays done on case studies. Observation checklists were used for evaluating changes in attitudes and skills.

Evaluation of workshop sessions: This revealed that participants wanted more information on women's health problems and suggested that the duration of this session be increased. Similarly, they wanted more lectures on menstrual problems and STDs. The session on communication skills was the most highly appreciated. Not only was it a new topic, the participants also appreciated the practical and entertaining training methods used for this session.

Two participants stated that they did not like the session on gender and health because they felt it was too long. 4 out of 16 participants did not like the use of role-plays as a training methodology. Since they were not used to this method, they found it difficult to express their thoughts through this medium.

All participants stated that refresher training courses should be held regularly for all doctors.

Final evaluation: An evaluation of participants done 18 months after the training shows that clinicians from the project area scored significantly higher than those from the non-project area with respect to knowledge and skills related to the four reproductive health conditions.

Continuing Medical Education Sessions (CMEs)

The pre- and post-training scores of the clinicians indicated that there were several topics in which they needed further training. It was decided to organise monthly meetings that would serve the purpose of Continuing Medical Education (CME). Both project wards were asked to conduct CMEs for their own clinicians. The honorary gynaecologist in one ward and the Medical Officer In-charge (MO.i/c Gynaecology) in the other, were designated conveners of the CMEs. Despite continuous efforts and encouragement, the practice of CME did not take root in one of the wards. In the other ward, however, it received an enthusiastic response.

Attendance in this ward has been almost 100 per cent for most of the CMEs. The fact that, in this ward, the doctors asked for a special guest lecture on 'adoption' in order to be better informed about the referral options available to couples unable to have children, reflects that they realise that social issues do have a bearing on the health of couples, especially that of women.

There appear to be two reasons for the lack of interest in conducting regular CMEs in the 'weak' ward. The high proportion of vacant Medical Officers' posts in this ward means that there is no interested 'critical mass'. The other reason seems to be a lack of motivated leadership.

Practice

After the refresher training, the clinicians were asked to start a weekly gynaecology OPD in dispensaries/health posts and to keep a note of the cases of RTIs, infertility, menstrual disorders and antenatal care that they treated at their clinics. The doctors were also asked to send a monthly report of these cases to the Medical Officer- Health (MOH) and to the project office. The response to this was naturally more enthusiastic in the ward where CME had been accepted. For most of the relevant period, the health posts and dispensaries in the other ward submitted a nil report.

Data for dispensaries and health posts in the enthusiastic ward show that female users of these facilities have used the services offered for the four selected conditions. In most of these cases, only symptomatic treatment was given without any per vaginum examination. Informal discussions with the providers revealed a number of practical problems that prevented them from conducting per vaginal examination in the management of such cases. Lack of privacy was the most commonly cited reason. In the initial phase, disposable gloves and vaginal pessaries were not available. Some of the primary facilities had less than the required number of speculum sets and other instruments needed for carrying out gynaecological examination. According to the doctors, this meant that fewer patients could be examined per day. Lack of appropriate sterilisers for used equipment and gloves was another problem. Some of the dispensaries had solved this problem by sending the instruments over to the nearest

health post for sterilisation. But this did not seem to be a feasible solution for all facilities. Once again, it appears that motivated doctors went ahead and solved the logistical problems through their own initiative; those who were indifferent used these problems as excuses to not provide the expanded range of services to women.

Gynaecological OPDs

With these experiences, some facilities were identified by the project for more intense inputs and closer monitoring to solve the problems and ensure the effective functioning of gynaecology OPDs. This involved regular visits to the facilities, discussing problems with the staff, and then presenting these problems to the higher officers. It also meant ensuring that the given facility had the basic requirements like equipment, drugs, privacy and trained staff to conduct gynaecology OPDs. The problem relating to shortage of drugs was solved by procuring medicines from Mumbai District AIDS Control Society. One day in the week was fixed to conduct gynaecology OPD in consultation with the staff. Community leaders were involved to ensure that the community was aware of the services available. Because of these efforts the attendance at the three weekly gynaecological OPDs that we have been successful in operationalising, is about 25 women per OPD. This number is significant when compared with average attendance of 10 patients per OPD day registered prior to this exercise.

Learnings and Recommendations for BMC

1. As the WCHP experience has shown, the monthly CME sessions in one ward provided a platform for providers from primary health care centres to discuss issues with peers and experts. Such interaction not only enriched their knowledge but also helped in improving the quality of care. Interest expressed by the clinicians in gaining more information about social issues associated with the gynaecological conditions was encouraging. Inputs on non-clinical subjects like adoption, violence against women and child abuse helped the doctors gain an insight into the social aspects of disease and health. Following from this experience, it is clear that clinicians need to be encouraged

to familiarise themselves with the social aspects of medical conditions, as this would help them in achieving better treatment outcomes.

CME also served as a forum for solving administrative problems, for example, lack of privacy for women, dysfunctional equipment, etc.

Since inputs given through the training programme are reinforced through the CME, it should become an integral part of all training programmes.

2. Conducting gynaecology OPDs at the health post/dispensary level requires continuous monitoring. Although in the two project wards this function was performed by the WCHP, it needs to be taken over by the MOH of respective wards. Clinical and administrative monitoring would help in achieving better treatment outcomes. Administrative monitoring could help in ensuring that instruments and drugs are available and that privacy is ensured. Mechanisms for such monitoring need to be integrated with the existing supervisory mechanisms, with appropriate checklists for both technical and administrative monitoring provided as an aid.
3. The WCHP training for Male Health Workers and Auxiliary Nurse Midwives (MPWs/ANMs) was not followed by regular CME sessions. It is probably due to this that no referrals were made by health-workers from the community. CME sessions should be conducted for all cadres. If necessary, two or three facilities could be grouped together for one CME for MPWs/ANMs.
4. Involvement of higher officers as well as grassroots level staff is essential for ensuring the quality of reproductive health services at the primary level.

Recommendations for Clinicians' Training in Urban RCH

- Building the capacity of key trainers is crucial for the effective implementation of RCH programmes. In the preparatory and planning phase, both time and budgetary resources should be provided for

this purpose, including ongoing supervision and support. The preparatory period could also be used for adapting the RCH modules to local needs.

- Participatory Training Methodology should be incorporated into the clinical training for training of trainers (TOT). Case studies and role-plays on clinical topics could be included in the sessions to reinforce learning.
- Checklists should be used to assess the clinical as well as social aspects of care provision during training situations.

Note

The authors would warmly like to acknowledge the contribution of Swati Pongurlekar, Anagha Pradhan and Korrie de Koning in the writing of this paper.

Annexure 10.1

Overview of the Clinicians' Training:

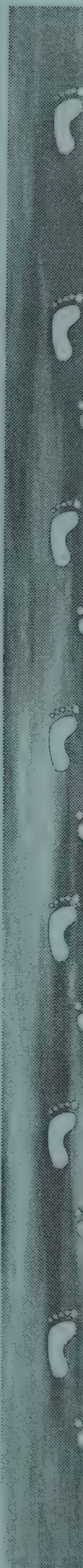
Objectives
Women's Health Programme : The participants should be able to <ol style="list-style-type: none"> 1. list women's common reproductive health problems; 2. discuss factors responsible for their poor health status.
Gender and Health : The participants should be able to <ol style="list-style-type: none"> 1. discuss the concept of gender in relation to health; 2. discuss how gender affects women's poor health status.
Scope of Health Post (HP) and Dispensary : The participants should be able to <ol style="list-style-type: none"> 1. describe the current situation of HP and dispensary; 2. discuss scope of HP and dispensary to provide gynec services.
Communication Skills : At the end of the session the participants will understand <ol style="list-style-type: none"> 1. the process of communication; 2. the requisites for effective two-way communication; 3. barriers to effective communication.
Counselling Skills : At the end of the session the participants will <ol style="list-style-type: none"> 1. be familiar with basic counselling theory (values, principles, approaches); 2. understand the counselling process.
Menstrual Problems : The participants should be able to <ol style="list-style-type: none"> 1. analyse women's perceptions of menstruation, clear related myths and misunderstandings; 2. describe types of menstrual problems; 3. describe their causes and clinical features; 4. differentiate between physiological and pathological variants in the menstrual pattern; 5. diagnose and manage some menstrual problems at the HP and dispensaries; 6. inform and counsel women.
Reproductive Tract Infections (RTIs) : The participants should be able to <ol style="list-style-type: none"> 1. describe causes of RTIs, STIs and leucorrhoea ; 2. describe clinical features of STIs and leucorrhoea; 3. differentiate between physiological and pathological leucorrhoea; 4. analyse social and gender factors affecting RTIs; 5. diagnose and treat RTIs; 6. counsel patients and their partners.
Pregnancy : The participants should be able to <ol style="list-style-type: none"> 1. conduct antenatal examination; 2. detect and refer high risk pregnancies; 3. impart information and counsel a pregnant woman.
Infertility : The participants should be able to <ol style="list-style-type: none"> 1. describe the causes and management of infertility; 2. understand the social and gender aspects of infertility; 3. do basic evaluation of the infertile couple and refer; 4. counsel infertile couples.

Session Objectives, Methodology and Evaluation

<i>Methodology</i>	<i>Evaluation</i>
Group discussion.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop
Discussion, brainstorming, exercises, presentation, storytelling.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop
Discussion, presentations	<ul style="list-style-type: none"> ● Documentation of the proceedings of the workshop
Group discussion, lecture, demonstration, exercises, role-plays.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants
Discussion, brainstorming, exercises, role play.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants
Lecture/discussion case studies for role-play and group discussion, field training.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants
Lecture, Group discussion, role plays, field training.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants
Group discussion, role plays, field training, case studies.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants
Lecture / Discussion role plays, field training.	<ul style="list-style-type: none"> ● Pre-Test and Post-Test ● Documentation of the proceedings of the workshop ● Observation checklist in the workshop for Group Work and in the field training for individual participants

Part 3

Educational Material
for Women's Health



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Chapter 11

**Screening Information, Education and
Communication (IEC)**

**Material from a Gender Lens
- CHETNA's Experience**

Pallavi Patel and Indu Capoor

Before we talk about reviewing IEC material from a gender perspective, we need to build a common understanding of what is meant by 'sex' and 'gender'. In many societies, the words 'sex' and 'gender' are used interchangeably. The word sex denotes the biological and physical differences between males and females. These are natural differences that exist in every family, community or country.

The social and cultural definition of men and women is called 'gender'. For example, society makes certain rules and perpetuates certain social practices: a girl must stay within the house, while a boy can go out; a girl will be given less food to eat and less time to play in comparison to a boy; special attention and resources are spent on a boy to enable him to get a good job in the future, while little or no attention is paid to a girl's education, etc. These differences are not natural. Nature produces males and females. Through the process of socialisation, families and society turn them into men and women, feminine and masculine.

We can see the impact of gender in our daily lives in the different ways in which girls and boys are socialised, in their behaviour, roles and responsibilities, qualities, control over productive work, reproduction, sexuality, employment opportunities, values and even language, all of which are biased against girls/women. Gender differences may differ from country to country, and even within the same country due factors relating to class, caste, race, religion, geographical area, historical period and so on. Some instances of gender impact in India are as follows:

- Girl children are deprived of adequate nutrition, health care, love and access to education, knowledge and respectability. This has a negative impact on their personality development and severely affects their self-esteem from childhood itself. Self-esteem emanates from a positive self-image, leading to self-confidence and a good opinion of oneself. Lack of self-confidence and self-respect makes it difficult for women to express themselves and consequently to confront situations of subordination or individual discrimination.
- Pregnancy is a natural, biological process. However, decisions about whether, when, how many times and how often to become pregnant are not part of any biological process. But in most families, it is the husband and/or the family elders who decide. The women are not consulted.
- The survival of all human beings involves consumption of food. Ideally, therefore, the activities associated with eating, i.e., cooking and cleaning, should be performed by both the sexes. But society considers this to be solely the woman's responsibility.
- Although crying is a natural response to sorrow, anguish or pain, society does not approve of boys who cry in public.
- Both men and women are capable of working outside the home. However, social norms demand that women work within the home while men work outside. Due to this gender division of labour, men are pressured to earn a livelihood to support the entire family, while women's work within the household is

neither valued nor recognised.

In brief, gender is social construct as a result of which

- There are unequal relations between women and men.
- Lower social, economic and political status for women.
- Women have access to fewer opportunities, a low level of exposure and education, lack mobility and are dependent on men; they also face discrimination in terms of food, love, health care, clothing, attitudes, behaviour, practices and values.
- Women lack self-confidence, identity, dignity, self-importance and articulation, which perpetuates constant fear.
- Women suffer from exploitation, oppression, subordination and violence, leading to poor self-esteem.

Low self-esteem prevents the development of decision-making capacities in women. They tolerate, or are forced to tolerate, violence in the family, workplace and society, such as physical abuse, mental torture and sexual harassment or abuse inflicted by the husband, in-laws, or by co-workers at the workplace. She is conditioned to regard her husband as a god, eats last and least and does not participate in any decision-making either in the family or the political sphere.

What Needs To Be Done

Women need to become aware of their rights as human beings. They also need to be able to access opportunities for economic activities and support services as well as emotional support. This will help to enhance their self-confidence, dignity and articulation, thereby creating a sense of well-being.

Improvement in self-esteem will lead to

- Feeling good about herself and having the confidence to speak out and act.
- Increased bargaining, negotiating power and the confidence to confront unfair treatment.

- Equal power relations and resource distribution.

All this in turn would lead to economic, social and political empowerment of women as individuals and as a collective.

Role of IEC

After the two major world conferences — the International Conference on Population and Development (ICPD) and Fourth World Conference on Women (FWCW) Beijing — that took place in the 1990s, several initiatives have been taken by NGOs and GOs to integrate the gender component in the implementation of health programmes. However, fewer efforts have been made to make IEC material more gender sensitive. IEC material plays a crucial role in creating gender-sensitive awareness, which may lead to positive and gender-sensitive behavioural change. It is therefore important for IEC material, particularly that related to women's and girls' health, to integrate the concept of gender discrimination. Since most designers, photographers and artists are socialised in a gender-biased environment, they tend to develop IEC material that is gender insensitive. By disseminating such material we indirectly perpetuate gender discrimination in our project areas. To address this issue, we have made efforts to share our experience of screening IEC material through a gender lens:

Review of IEC Material through a Gender Lens

We have discussed the process of review at two levels, a Rapid Gender Review and a Detailed Gender Review. The Rapid Gender Review facilitates a quick scan of the material for its gender sensitivity in the following areas:

- 1) general information given on how to use the material;
- 2) text /layout;
- 3) illustrations.

The Detailed Gender Review is used for reviewing the process of developing the health education material. (Please note that the gender review given here is not comprehensive but only provides broad guidelines

that can be adapted to suit your own socio-cultural environment.)

Rapid Gender Review

Information on How to Use the Material

The effective use of IEC material broadly depends on instructions provided for its use. If a conscious attempt has been made to integrate gender aspects into the material, then this fact needs to be highlighted in the instructions. Existence of the following information would indicate that the designer has taken care of the gender aspects.

- Provision of guidelines to the user about gender-sensitive aspects included in the material and how to highlight these while using the material.

For example, if the material attempts to portray women as agriculturalists or doctors in order to challenge the stereotype of her as domestic worker, then this should be specified in the guidelines to the user, along with tips on how to highlight it while conducting a session on health education.

Layout of Material

Women and girls, particularly in India and other South Asian countries, are less literate and have less exposure to the world in comparison to their male counterparts. Already overburdened with household and other chores, many Indian women, if literate, tend to read while continuing with their routine chores. It is therefore necessary to ensure that short sentences are used, that the language used is local and simple, and that it matches with the educational level of the beneficiaries. It is also important to ensure that the layout is simple, uses clear, legible and large-sized fonts, with generous margins on all four sides and enough space between lines.

Language and Text

The language used frequently and easily reflects the gender biases of the creator of the IEC material. Certain words have a negative connotation and should be avoided; instead, the material should use

alternative words that do not reflect any gender bias.

Gender biased words	Alternative
Illiterate/ignorant (usually used for women)	Uninformed
Prostitute	Sex worker

Important Tips on How to Review for Gender Sensitivity

A text can be considered gender sensitive if it

- Includes gender-neutral terminology like chairperson, humankind, human power, etc.
- Discourages social and cultural practices, which are harmful for women's health and development. Take, for example, the message

'Menstruation is a natural process. Do not consider it dirty and isolate women and girls from household activities and social and religious ceremonies.'

Many Indian societies consider menstruation to be dirty and young girls and women who are menstruating are required to sit separately in one corner of the house. This custom deeply affects their self-esteem.

- Includes information on helpful traditional health practices. Recognition of the existing knowledge of women can serve as a powerful tool for empowerment.
- Emphasises women's involvement in decision-making processes to ensure their control over available resources.
- Includes various strategies for women's empowerment, like organizing, getting elected in local government, male involvement in contraception, etc.
- Focuses on human and women rights or inclusion of information related to the protective rights of women in the context of the particular IEC topic. For example, in India, a woman cannot be

summoned to the police station after dusk (sunset). Most women are not aware of this right. Any material related to violence needs to focus on this.

- The text needs to be field-tested with the help of users (final beneficiaries) and gender experts. Look for details given about field-testing. They may be printed on the front inside or the back cover page. Field-testing is important because the perception of the text's designer and the perception of community need not be same.

Illustrations

Illustrations are a very powerful medium of communication. It is therefore very important that they are used carefully to encourage gender sensitivity. It is thus necessary to ensure that illustrations

- do not emphasise or reiterate stereotypical roles of women and girls.
- make an effort to break traditional gender roles. For example, an illustration depicting women as professionals, or men/boys helping in household work and girls playing.
- do not further degrade the image of women.
- depict a positive image of women: assertive, taking initiative, in the role of a leader, etc.
- do not indicate any hierarchy between men and women.



Man performing household work



Woman as a professional/ medical officer.

Detailed Gender Review

A detailed gender review uses the gender lens to provide a critical insight

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HEALTH CELL



Re-emphasizing hierarchy between man and woman



Focusing on equality

not only on the health education material itself but also the process of its development.

Identification of the Topic

If the material is to be needs based, the identification of an appropriate topic is crucial, otherwise all the resources spent on making the material, however attractive it might be, will go waste. In reviewing the process of topic identification, the following question may be asked:

- Is the topic chosen an explicit need of the identified group of the community with whom you are working?

For example, if the issue were related to adolescents, it would be wise to ensure that both girls and boys express the need. This could also be determined through observations, focus group discussions and past experiences with the particular age group.

Analysing Existing Health Situation or Concerns from a Gender Perspective

Analysing the health situation from a gender perspective is a process wherein one determines how the particular situation affects both women and men. The key issues that specifically affect the health of women and girls are gender division of labour; access to and control over resources and the distribution of resources; social, economic and environmental factors which influence all of the above; and decision-making capacity. Incorporating a gender perspective into IEC involves applying gender analysis.

Ask the following questions to know whether such analysis has taken place or not:

- Have any efforts been made to conduct research or collect information related to selected topics from both men and women and other concerned people? This will provide an insight about the complexity of the issue from the medical, social, religious and political perspectives prior to the conceptualisation of the educational messages.

For example, if the issue identified for health education is hygiene during menstruation, data needs to be collected from the following people:

From whom	Type of Information
Adolescent girls and women	<ul style="list-style-type: none">• Different terminology used to explain the process of menstruation, reproductive organs and other related terms related to the process of menstruation• The existing practices among the girls and women related to menstrual hygiene and why• Beliefs related to menstruation
Health personnel	<ul style="list-style-type: none">• Health problems that they have observed due to poor hygiene during menstruation
Religious beliefs related to menstruation	<ul style="list-style-type: none">• From existing religious texts, older women, religious priests
Men and boys	<ul style="list-style-type: none">• Knowledge of men and women about menstruation

Women’s health is a complex issue and dealing with it merely from a medical perspective may not be able to address the comprehensive health concerns of women. It needs to be looked at in a holistic manner and therefore collecting information from various sources is very crucial.

The following are some examples of socio-cultural factors that affect women’s health and can be included in the health education material.

Complications during pregnancy: The points that need to be highlighted are:

- Headache and giddiness during pregnancy.
- Oedema on the hands and feet.
- Convulsions.
- Haemorrhage (excessive bleeding).
- Pain in the abdomen anytime during the pregnancy.

While developing messages for these concerns, it is very important to keep in view that in several countries one of the reasons for hemorrhage is domestic violence. It is the experience of several fieldworkers that the husband beats the wife on the abdomen during pregnancy knowing full well that it is extremely painful and she will obey him only if he does that.

Infertility: Along with the necessary medical information, the following points also need to be highlighted:

- Medical check-up of the couple is necessary to know the reason for infertility.
- The checkup of the man should be conducted first. Only if there is no medical problem with the man should a check-up of the woman take place.
- A message about adopting a child is critical. Adoption is frowned upon in the Indian context and this needs to be changed.

Highlighting the Roles of Different Stakeholders

To improve women's health, disseminating messages only to women may not lead to expected results. Action to meet women's health requirements needs to be taken by family members as well as the community. This issue needs to be addressed in health education material.

For instance, in India, information related to infertility needs to address actions at the following levels:

- **As a woman:** Never feel that you have to necessarily give birth to a child. Adoption of a child is a better alternative than blaming yourself. Go ahead and adopt a child. You will be a role model and set a new trend in your society.
- **As a family member:** Do not only blame the woman for not giving

birth to a child. Encourage the couple to undertake a medical examination. If the couple still cannot conceive a child, encourage them to adopt one. Remember, religious rituals cannot cure infertility. Do not force woman to go through them. This may affect her self-esteem. Remarriage is not the answer to infertility. It is an insult to woman and womankind. Never encourage your male family member to do that.

- **As the man of the family:** Be sensitive to the social harassment of woman for not bearing a child — a fact for which you may be responsible. If another couple in your family is facing the problem of childlessness, tell them about the necessary medical check-ups and the possibility of adopting a child. Childlessness does not mean the end of life; there is lot more to life than that. Explain this to other friends and family members.
- **As a doctor:** To identify the cause of infertility in a couple, always check out the man first. Take some time to scientifically explain to the couple about conception.

Process of Developing Material

The process of material development includes a number of steps, such as conceptualisation, message formation, selection of illustrations and layout. It is critical that the designers, illustrators and translators of the material undergo a process of gender sensitisation. If they are not gender sensitive, his/her gender biases are likely to be reflected at each stage of material development. The following are some examples that explain how the understanding of a gender-insensitive person reflects at various levels of material development.

Conceptualisation: Some extensively disseminated health education material on contraception included a comparison of the condom with the IUD. One comparison made was as follows:

IUD	Condom
Once you get IUD inserted in your womb, you need not bother to wear a condom every day.	Condom needs to be used every time you perform penetrative sex. It is cumbersome.

This reflects the man's gender-biased perception on contraception rather than rational information to the user about the strengths and limitations of different contraceptive methods.

Message formation: A health education message in a poster addressed to pregnant women in an Indian language said:

‘Eat more nutritious food as there is going to be an entry of a prince in your house.’

This indicates strong preference for a son, and is probably a reflection of the bias of the person who has formulated the message.

Illustrations: Due to deep-rooted gender-biased socialisation, the majority of our artists tend to draw gender-insensitive illustrations. Some common examples are:

- In the illustrations of children they tend to draw more boys than girls, particularly those studying or playing.
- They forget the existence of minority communities. In the Indian context, they usually make illustrations of the dominant Hindu community. Drawings of girls and women wearing a ‘bindi’ on the forehead emphasises the Hindu religion. Similarly, in Muslim countries, women wearing ‘burkhas’ highlights the dominant Muslim religion.

Review of Specific Issues Concerning Gender Inequality

Decision-making/Access to Resources: In a gender-biased, patriarchal society, particularly in India and other South Asian countries, women have very few opportunities to take decisions, even for themselves. When they do get an opportunity, they tend to seek consent from other family members before taking the decision. It is therefore very important that the material focuses on situations where women and girls are given space to share their needs and take decisions.

For example, health education material on the nutritional requirements of women needs to communicate the following gender-sensitive message

along with other technical information. It can be formulated differently based on the type of material. It can either be in the form of a text or an illustration:

Gender sensitive message



“Always sit together to eat meals.”

This message reflects the critical need to equally share available resources between all the family members as per their requirement. Sitting together for eating provides a space to women and girls to decide how much to eat and what to eat. In countries like India, Bangladesh, Nepal and Pakistan, women usually eat last, least and leftovers and have no control over the available cooked food, This affects their health and well-being.

Division of labour: In a patriarchal society, women are overburdened with multiple roles of production and reproduction and their labour at home is usually unpaid and unappreciated. Men usually have paid jobs, by virtue of which they can enjoy the power of decision-making and control over the resources. There is a great need to bring equality in the division of labour, which will eventually lead to better control and access over resources among men and women. This will ultimately bring about positive change in the health of women. Let us see some examples of gender-insensitive and sensitive text and illustrations depicting this concept.

In India and other South Asian and African countries, health education material related to care during illness is usually addressed only to women. This is because in a patriarchal society, care of the elderly and ill people is considered women’s responsibility.

The following illustration clearly communicates the gender biases of the illustrator by showing only the mother and the girl child taking care of an ill child in the family.



Source: *Basic Health Messages 2nd Edition* (June 1990), UNICEF Kampala

Making an illustration gender sensitive: Material related to women's health need for adequate rest usually does not include the contribution that men can make. A message including the role men in the family can play to ensure the health of women can take the following form and be addressed to men:

‘Do not be ashamed of doing household work. Sharing household responsibilities will allow women to get adequate rest. Rest and leisure is critical for both men and women.’

Please note that though this may sound culturally alien, by doing this you can become the initiator of social change.

Ownership and control over resources: Since women in the Indian context lack ownership of money and other resources, they are usually hesitant to take timely decisions related to their own health. For example, it is common for women to delay approaching the health centre even in cases of complications relating to pregnancy or delivery. The delay starts with the woman herself and then next at the level of husband or other family members.

Material related to care during pregnancy should address both husbands and wives, and advise them to save money for coping with possible emergencies during pregnancy. By focusing on sharing of financial

resources for the well-being of the woman, such messages will increase the access and control of women over resources. Money saved for a specific cause will also encourage both wives and husbands to take timely decisions to cope with emergencies.



Gestures of women depicting confidence



Women negotiating about their health needs with health official



Women feeling empowered being together

Enhancement of self-esteem: As discussed earlier, improvement in self-esteem is an important step towards women's health and development. A positive self-image includes confidence, having negotiation and bargaining power, equal power relations, feeling happy, etc. Health education material needs to focus on this, perhaps through illustrations depicting her position in society,

Last, but not less important, look for information on the strategy given for the empowerment of women. This is crucial. The strategies suggested would need to be local, realistic and replicable. They should be aimed at empowering all the players involved in the process rather than a particular

part of society/community.

We hope that our experiences of reviewing health education material from a gender lens has provided some insights about how to make such material more gender sensitive. As mentioned earlier, this is not comprehensive paper. We suggest that you add your own experiences to enrich it further.

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*Chapter 12***Information — Who Produces? Who Uses?**
An Experience in Material Production

Sama

When we began our health training activities a few years ago, we felt the need for two kinds of material; one, to support the training process itself, and another for participants to take home as reference material. Since no one in our group was particularly proficient in preparing material other than in written text, we felt we should try and gather other sorts of existing material from various sources that would suit our training needs. Our health training was aimed at providing a holistic understanding of health to rural, largely semi-literate tribal women and men. The goal was to enable them to take care of most of their health requirements, as well as to provide an understanding of the macro issues of health politics, policies, infrastructure and services, so that they could make appropriate interventions. Our search for material was in this context.

Mainstream Curricula

Since part of our training curriculum focuses on understanding the way the human body functions, we began our search by referring to

school textbooks on biology/anatomy and reference material aimed at school children. Although we did find some relevant information that we could use, by and large we found school textbooks rather limited for our purpose, and perhaps rightly so. The junior-level textbooks cater strictly to children and do not contain adequate information that is necessary for adult men and women. Although the books for high school carry more information, their language is too complex, requiring higher levels of literacy. In addition, these textbooks lacked any kind of socio-political analysis as well as something that was very important to us, i.e., a gender perspective.

Among reference books for school children, a few glossy and remarkably expensive coffee-table books on the human body did contain some pictures and diagrams that we found useful. There were many others on health and the human body, probably aimed at an adult readership and equally glossy and more expensive, but they focused more on the nude female form rather than on health.

IEC Material

We then widened our search to look at what the government produces, because the government does allocate substantial funds for material production and publicity. We learnt that the government has identified health education as an important vehicle for the promotion of health messages. Its Information, Education and Communication department (IEC) has been involved in developing health awareness and education material in a decentralised manner. According to the Annual Report of the government's Ministry of Health and Family Welfare (MOHFW),

'The main aim of the IEC of the National Family Welfare Programme is mainly to create an effective communication strategy to inform the masses about the means of Family Welfare Programme, educate them about the perils of overpopulation and motivate and persuade them to adopt small family norm, using all possible channels of the media.'

However, we found a number of limitations in the government-produced material:

1. Most of it does not address health holistically; it is perceived only from an illness and treatment perspective. Diseases are addressed in isolation with a symptomatic approach, without considering the more fundamental factors behind such diseases or ill health, such as socio-political and economic factors. The other problem in all the material that is produced is that it tends to:
 - a) make the poor responsible for their ill health;
 - b) ignore and undermine local perceptions and knowledge of health;
 - c) fail to address gender issues and limit women to their roles as nurturers and carers, confined to the management of the home and family. That women need to access information beyond this, or that other factors influence them, is not part of its agenda of education for women.
2. The main focus of the government IEC material is on family planning and the importance of spacing births, immunisation, or educating ‘people’ on personal hygiene and treatment for common ailments like diarrhoea. There are a number of posters on vertical programmes such as malaria and HIV/AIDS, and these again talk only about prevention and treatment. Crucial linkages with issues such as gender, poverty or access to health services, are missing, even while addressing reproductive health or family planning.
3. It appears that the material has not been produced in a decentralised manner. It has been developed at the centre or state level and merely translated into local languages. The form, style and context of most material appears irrelevant and difficult to relate to. The language is complicated and not adapted to particular local contexts.

Alternative Resources

Interestingly, we found some innovative work done by women’s groups and NGOs working on health. There is substantial information on

reproductive and general health issues, HIV/AIDS and reviving traditional health care practices. Material by women's groups has tried to address the 'private' issues that are usually shrouded in shame and guilt, such as reproductive health and sexuality. Myths and perceptions of urban and rural women of these issues are also addressed sensitively. *Sharir Ki Jaankaari*, a booklet produced by Kali for Women, is able to create enthusiasm and curiosity among women about getting to know their bodies. It also looks at patriarchy and other forces that control women's access to health services. Nirantar's three-part health manual, *Swaasthya Ki Khoj Mein*, is another resource that we found useful. The manual looks at health from a holistic perspective, dealing elaborately with basic needs (drinking water, food and nutrition, health services) and the real situations that women face in their day-to-day lives. It also explains to the users the interactive processes that can be used to discuss perspectives on health with people at the grassroots. Various activities, case studies and stories can be used creatively to prevent learners from getting bored. We also found some interesting training tools and models developed by Ideal in Ahmedabad and Eklavya in Madhya Pradesh.

However, not all material from the NGOs is useful or appropriate. We came across several organisations that had blindly followed the methodology and perception of the mainstream, without attempting to achieve a balance between information and perspective, contextualising and adaptation.

When Users Develop Their Own Material

In the beginning, we developed material from all the sources listed earlier, by organising the relevant information in simple language. We would spend hours simplifying and adapting information that we had collected and contextualising it for local situations. Very soon we realised that our local partners were not only eager to participate in the process, they also had the requisite creativity to do so effectively. We learnt that health-workers could be part of creating training and reference material that is responsive to their needs.

Through this process, our partner groups produced a whole range of

training tools. During our training with Girijana Deepika (Andhra Pradesh), the trainers made excellent models of the various systems of the human body with the information they gained from the training, using local skills and local material. Using cloth as a background for their models, they drew an outline of the human body on it. The different organs were cut out from pieces of foam, coloured and stuck on the cloth with a simple adhesive. Blood vessels were made out of plastic tubes of varying dimensions and colour. They used local names for the body parts, and other written information that could be easily understood in the region. Some models had two or three layers to show the functioning of a particular system in greater detail, all using cloth that could be lifted to reveal the different layers. We ourselves could never have made such a range of interesting, attractive and informative material. Later, when we used this material in other language areas, we found that people could understand it quite easily.

It is not easy to explain to neo-literates the process of conception and such factors as dates and sperm count. We therefore felt the need to simplify the complex charts that are normally used to explain the phenomenon. Seeing the inherent creativity of the local people, we discussed the idea of developing a game that could easily translate the information. We were thinking of a fertility wheel while developing health curriculum for Nirantar, and we felt that we could develop this idea further in this context.

We cut out two circular cardboard wheels, one smaller than the other, and placed them on top of each other, securing them at the centre so that the smaller wheel could turn independently. We divided the larger wheel into 29 parts to represent the days of the menstrual cycle. The smaller wheel was also divided into segments in which we drew varying concentration of sperms. We called that the sperm wheel. A thin, long piece of straw was secured to the centre as a pointer. Now, as we turned the sperm wheel, the pointer also moved independently. After a while, both the pointer and the sperm wheel came to a halt, again independently of each other, pointing simultaneously at a certain day of the cycle on the larger, bottom wheel and a certain concentration of sperms in the smaller one. Later, we colour coded

the various periods like menstruation, safe period, etc.

When we tried the game out with participants, the result was amazing. A boring two-hour lecture was transformed into an exciting game through which understanding the process of conception became very easy. In addition, the game, which we later named the 'fertility wheel', also addressed other issues relating to fertility. For example, the notion of blaming the woman for not conceiving: the wheel clearly showed that even if a woman is in her fertile period, her partner may not have the adequate sperm count for conception to occur. Thus, the myth of the woman being responsible for not conceiving was easily broken. Subsequently, a product designer further developed the basic design by using more durable material, so that others could use the wheel as well.

As we progressed from the functioning of the human body to topics in the socio-political and cultural arena, participants came up with more and more interesting material. They developed a number of pictorial scrolls that explained how the tribals were alienated from the forest and their culture. Not only were the scrolls colourful and attractive, they had an immense impact on the viewers wherever we took them. We encourage the production of this sort material in all our training programmes. In addition to being effective, such material is extremely low-cost as it is made made using locally available resources.

Some of our trainee groups felt the need for a different kind of material that could be used for larger communication. *Jampai* – 'orchid' in Misching language — was born out of a series of Training of Trainers Workshops on gender and health, held with participants from different states in the North East. Made at minimal cost with a combination of photographs, illustrations and text, this broadsheet reflected the process and content of all the workshops that the participants attended and provided an overview of each phase of the training. *Jampai*'s purpose was to provide other groups ideas on how to approach gender and health issues through activities and role-plays. Though the process of producing *Jampai* was not very elaborate, it generated tremendous excitement among the participants. They were keen to be a part of the production process and take back from the workshop something that they could use to communicate with their own groups of trainees.

We see the process of material production as an immensely empowering one. In addition to addressing the need for information, it also breaks a number of stereotypes, be it gender, caste, class, urban or rural. More than anything else, when material is produced by women and the rural and underprivileged people for their own needs, it demolishes the structural presumption that concentrates information in the hands of the urban, upper caste, non-tribal men.

*Chapter 13***Mahiticha Bagicha**
Broadsheet on Reproductive Tract Infections

Swati Pongurlekar, Manjiri Maslekar and
Neera Kewalramani

The Women-Centred Health Project (WCHP) is a collaboration between the Public Health Department of the Brihanmumbai Municipal Corporation (BMC), SAHAJ (Society for Health Alternatives), a non government organisation, Liverpool School of Tropical Medicine and the Royal Tropical Institute (KIT) at Amsterdam. WCHP has been working with the Public Health Department of the BMC to improve the quality of reproductive and sexual health services provided by primary and secondary-level health care facilities. Making the services user-friendly and gender-sensitive has been the focus of all the activities carried out to fulfil this goal.

The project believes in a 'women-centred approach', which translates into providing women with comprehensive health care services in all their life phases. It functions through the existing health posts and dispensaries that act as primary health care centres (PHCs) set up in urban neighbourhoods for outreach services. After the inception of the population control programme at the national level, health posts in Mumbai were established in 1988 to provide Family Welfare and Mother and Child Health care services. These health posts provided family planning,

child immunisation and disease control services under the India Population Project (V), a World Bank aided programme. While the health posts are primarily responsible for preventive and promotive health care, the dispensaries provide curative services.

Women and men in the community perceive the health posts as family planning centres rather than as centres for women's comprehensive health care, as envisioned under the Child Survival and Safe Motherhood programme that was introduced in 1992. The dispensaries are either used for minor health problems like coughs and colds or are underutilised. **The underutilisation is because people tend to go directly to secondary and tertiary care centres.** They perceive the bigger hospitals as being better equipped in terms of personnel, services and medicines.

The baseline studies done by WCHP and the studies on reproductive health done earlier within BMC indicated that women use tertiary or secondary hospitals for their reproductive health problems. Exit interviews and a waiting-time study showed that on an average, women have to wait for two hours and three hours in the secondary and tertiary-level hospitals respectively, and their information needs are not fulfilled due to the rush and overload of patients on the medical officers. Also, the lack of systematic referral systems means that adequate patient follow-up cannot be ensured. On the other hand, some of the health posts and dispensaries are underutilised, despite the fact that have they adequate infrastructure comprising doctors, Public Health Nurses (PHNs), Auxiliary Nurse Midwives (ANMs), Male Health Workers (MPWs) and Community Health Volunteers who reach out to the community through home visits.

The project therefore explored the possibility of providing some reproductive health services at the PHCs. The medical officers attached to the health post and dispensaries expressed a need for training if they were expected to manage gynaecological conditions. WCHP selected four major gynaecological conditions for which services could be provided at the health post and dispensary level, namely, menstrual disorders, reproductive tract infections (RTIs), infertility and antenatal care. Apart from training, efforts were also made to make the infrastructure conducive for running a weekly gynaecological clinic, including making the necessary,

medicines and equipment available to the trained doctors. This was followed by training of paramedical and community-level staff of health posts and dispensaries. Along with providing services, it was felt that the women would need to be educated if they were to properly use the services being offered and if their compliance with the treatment and preventive measures was to be ensured.

Providing information and holding group discussions on reproductive and sexual health issues was identified as a strategy to empower women to take treatment-seeking and preventive decisions. The existing information, education and communication (IEC) materials available to discuss these issues with women in the community were explored and reviewed with the help of the IEC Cell. It was found that the material, messages and visuals were not always culture or gender-sensitive. The main reason for this was that most of this material was used in the form that it was provided by the central or state governments and was probably created by an artist sitting in an office without much contact with the field reality. It was also found that the material had not been pre-tested with the people in the community due to time constraints, possibly because the artists had been assigned the task of designing the material in a last-minute and ad hoc fashion. Thus, when some of the existing material was field-tested, it was found that the people did not understand the intended messages and interpreted the pictures differently.

The available material was thus not useful for starting the process of empowerment in the community. Also, there was not much material on RTIs, which WHCP wanted to use as part of the gynaecological service package to be offered at the health post and in the surrounding areas. Together with the IEC Cell, it therefore decided to demonstrate the process of participatory material development to the staff of the IEC Cell and the health care providers.

WCHP began by forming a core committee comprising IEC Cell staff and representatives of all cadres of health care providers, namely, Community Health Volunteers, ANMs, MPWs, doctors and Community Development Officers. Training in communication skills, the concept of health promotion and effective use of communication media was organised for this group. The committee members helped in conducting focus group

discussions (FGDs) in the *bastis* to find out media preferences of different groups of people. Analysis of the FGDs showed that people prefer to be engaged in dialogue and discussion rather than only being shown films and posters. This finding formed the basis of motivating the health care providers and IEC Cell staff members to produce people-friendly material that could be used to generate discussion and dialogue.

The production of material on RTIs began with FGDs with men and women, to find out their perceptions and beliefs about the causes and treatment of RTIs and measures that could be taken to prevent them; **and the health-seeking behaviour in the RTI context.** The core group members helped to organise and facilitate these FGDs in their areas of work. Some of the discussions were held with the help of NGOs working on women's issues. Information gathered from the FGDs was then compiled and analysed to determine the information needs of men and women with regard to RTIs. This report was sent to all the core group members and NGOs.

Following this, a four-day workshop was organised for core group members and the representatives of NGOs who had participated in conducting FGDs. Community Health Volunteers represented the perspective of women in the workshop, the objective of which was to prepare material on RTIs based on the findings that had emerged through the discussions. Resource persons from SAMA, an organisation with expertise in participatory material development, facilitated the workshop, which included sessions on the importance of making the material interesting, for specific groups of people in the community. The principles of creating material for neo-literates, like the use of simple language and visuals, were also emphasised.

While working in small groups during the workshop, participants came up with a range of creative stories, poems and pictures depicting causes, treatment, partner treatment and prevention of RTIs. In the larger group, it was decided to combine all the creative bits that the small groups had come up with into one big poster. Two drawing sheets were pasted together to accommodate all the pieces. As group members stuck their stories and pictures together, comprehensive information on RTIs emerged. The members then drew small designs and patterns to border

the text. Group members suggested names for the poster, now termed as a 'broadsheet', all of which were then put up on the blackboard and polled to select one name. *Mahiticha Bagicha*, meaning 'Garden of Information', was unanimously chosen to be the most appropriate name. This 'garden' was then pre-tested with a group of men and women in the hospital where the workshop was held, and on the basis of this, changes were made in the draft of the broadsheet. As a follow-up activity, it was decided to pre-test the broadsheet with a larger number of community groups outside the hospital.

The feedback from different pre-testing sessions with men and women was compiled and the text and pictures of the broadsheet modified accordingly. The final poster, which is 30" x 40", contains information on the following issues:

- Causes and symptoms of RTIs in men and women.
- Socio-economic, cultural and gender factors affecting the susceptibility of men and women to RTIs.
- Examination procedures.
- Treatment.
- Partner treatment.
- Treatment centres and procedures.
- Factors affecting treatment-seeking behaviour.
- Prevention and information on 'safe sex' practices.
- Responsibilities of men and women in preventing the infections as well as with regard to treatment compliance.

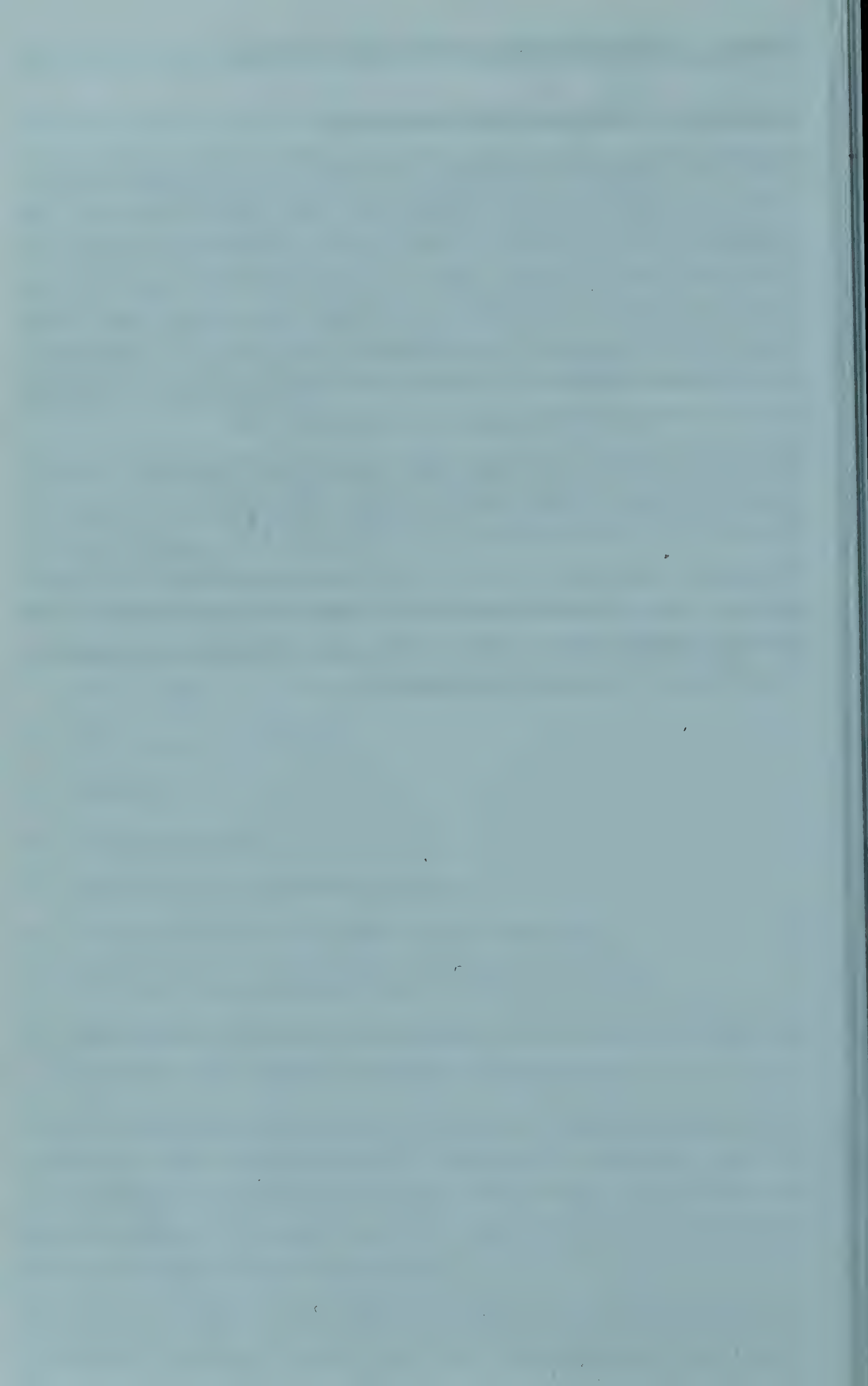
The broadsheet can be hung on the wall in gynaecological clinics, where people can read it while they wait; it can also be effectively used for group discussions in the community. WCHP also prepared a set of guidelines to help facilitators in a group situation to initiate discussions on the issues mentioned in the broadsheet.

The poster is currently being used by WCHP to train community health volunteers in the health posts where the Gynaecological Outpatients'

Department (OPD) has started functioning.

The project also plans to monitor group discussions in the community to assess the response to the broadsheet. The checklist provided to facilitators and evaluators of these sessions includes information on preparation for the session, effective group facilitation skills, use of simple language, techniques of providing information, conducting discussion on issues and participation by the group. The guidelines also include information on how to measure the impact of and the extent to which the broadsheet is used in the field.

Because of its unusually large size, printing the broadsheet created some problems, which delayed the availability of the poster. However, the process that was followed in the making of the broadsheet (beginning with the FGDs in the community to the final editing) was well worth the effort because it exposed the IEC Cell staff and health care providers of the core committee to the rigours of participatory material development.



Part 4

Traditional Systems of Medicines and Women's Health

1875

1875

1875

1875

*Chapter 14***Recovering Women's Healing Knowledge**
The Shodhini Experience

Smita Bajpai

Since ancient times in India, health care has largely been the domain of women who acquired deep and collective insight into healing from their forebears and through their own experience. Practised informally and passed on orally over generations, women's healing knowledge has been largely overlooked by the 'development' process. They are not recognised as healers, and the indigenous healing systems they practise are today on the verge of extinction. At the same time, the formal health care systems – not only Allopathy but also Ayurveda, Homeopathy, Siddha, Yoga and so on – fall short of meeting women's health needs. In this context, a viable option lies in the validation and integration of indigenous healing knowledge existing in communities, and involvement of women healers in the health care system.

During the late 1980s and early 1990s, Shodhini undertook a study of women's healing traditions with a view to empower them through validating and strengthening their knowledge base, as well as to address some common health concerns faced by women. Here, we describe the methodology adopted by Shodhini to learn about and

validate women's healing knowledge and to investigate some of the emerging issues.

Shodhini comprises a group of women researchers who came together to address neglected health care concerns of women by adopting a woman-centred approach. It formed as a result of interactions during a national consultation of women's groups working in health that was organised at Society for Rural Education and Development in Tamil Nadu in 1987. The consultation threw up three main issues:

- urban women were keen to learn about rural women's healing knowledge,
- little was known about non-allopathic ways to meet women's common problems, and
- women's traditional knowledge of managing health problems appeared to be dying out.

First formed as 'Action Research on Alternative Medicine and Women's Health', the small group later re-named itself as Shodhini. The original convenor was Rina Nissim, a Geneva-based qualified nurse trained in gynaecology and natural healing, who brought to the collective her vast experience of researching with herbs in gynaecology.

Shodhini sought to empower local women by:

- validating their traditional knowledge of healing,
- training local women in basic gynaecology to increase their control over their own bodies and their own health,
- focusing on medicinal herbs to increase women's control over technology and resources.

Shodhini's prime focus has been to discover ways of health care that would meaningfully respond to the health needs of women, especially those who are socio-economically marginalised. Adopting a woman-oriented approach, the effort has been to evolve a system of simple, natural and cost-effective health care, largely based on locally available herbs.

Table 14.1
Members of Shodhini

Local Organisations	Action India & Sabla Mahila Sangh, New Delhi AIKYA, Bangalore, Karnataka Deccan Development Society, Hyderabad, Andhra Pradesh SARTHI & N. M. Sadguru Water and Development Fdn., Gujarat Vikalp, Saharanpur, Uttar Pradesh Eklavya, Dewas, Madhya Pradesh.
Support Organisations & Networks	CHETNA, Ahmedabad, Gujarat SAHAJ, Vadodara, Gujarat Jagori, New Delhi Anveshi, Hyderabad, Andhra Pradesh.
Support Persons	Indira Balachandran, Phytochemist, Arya Vaidya Shala, Kottakal, Kerala Shyama Narang, Gynaecologist based in Bangalore Tanushree Gangopadhyay, Journalist based in Ahmedabad.

Three Phases

Shodhini's work progressed through three interweaving phases.

First Phase (1989-1990)

Identification of local women healers and collection of information on plants and natural elements commonly used for women's health problems.

Second Phase (1991-1993)

Training local women health-workers and healers in herbal medicine and basic gynaecology using a holistic 'self-help' approach.

Developing a team of barefoot gynaecologists to continue and sustain the development of women's health care alternatives.

Systematically field-testing and validating the use of common herbs at the community level.

Third Phase (1993-1997)

Consolidation and documentation of experiences, and reporting and publishing the findings.

Data Collection and Processing, 1989-1990

Through a series of meetings, discussions and dialogue with regional groups, a list of common but neglected women's health problems was prepared. These included:

- Problems of menstruation and the menstrual cycle.
- Infections of the urinary tract and vagina.
- Tumours of the womb and cervix.
- Problems related to pregnancy, childbirth and breast-feeding (anaemia, nausea, lactation failure, etc.).
- Other problems (aches and pains, weakness, genital prolapse, fatigue and depression).

Following this, research efforts were planned and geared to address these health concerns. A standardised sheet was prepared to collect information on herbal usage. Ingredients were measured using small spring balances. Data collection took 18 months. The persons who provided information were local women, *dais* (traditional midwives) and healers, both women and men. Information was also collected from secondary textual sources.

The data, comprising 411 entries on herbal usage from Gujarat, Karnataka, Tamil Nadu, Uttar Pradesh, Andhra Pradesh and Madhya Pradesh and including 176 from secondary sources, was then computerised. Seventy of the plants were recommended more than once for same complaint from different regions, and some herbs were cited at least twice or thrice by different healers. This helped to reinforce the field data, especially when secondary references to a plant could not be found.

The final list of plants comprised 252 species. These were checked against standard literature on medicinal plants and were assigned to category A, B or C according to their mention in literature (see Table 14.2).

Testing Plants through Use, 1991-1993

The second phase consisted of testing selected herbs through use by

Table 14.2
Categorisation of Medicinal Plants

A	Herbs mentioned as having the same properties and used for the same symptoms as healers	120
B	Properties indicate use, but not for same symptoms as healers	118
C	Properties documented as toxic or dangerous	014
	Total number of plants	252

healers in women’s illnesses. Three field groups participated in this phase: Aikya (Bangalore), DDS (Hyderabad) and SARTHI (Panchmahals, Gujarat).

Training

In each location, three-day training workshops were held at monthly intervals with women health-workers, including local women healers. Using participatory learning methodology, the training aimed to enhance their skills in recording ‘health-stories’, examining women, recognising and treating specific conditions, and counselling to avoid recurrences. Women were encouraged and guided to form ‘self-help’ health groups that could meet regularly and deal with common problems. The process not only helped the women to learn about their bodies and deal with common ailments, it also boosted their self-esteem and self-confidence. Workshop content was decided according to needs expressed by the participants. As most of them had low literacy levels, the organisers developed pictorial case sheets with their input. Practise sessions strengthened their record-keeping skills. It was difficult to coax them to understand the need for detailed documentation of stories, examination and arriving at some conclusion before suggesting remedies. Similarly, it was even more difficult to convince them of the necessity for systematic follow-up and maintenance of records.

The early workshops centred on the learning process within the group of Shodhini members and women belonging to local health groups. Once skills were upgraded and the women felt confident, they ventured out in

their communities.

At the community level, a process to identify women with health problems was initiated by a door-to-door survey of particular localities or villages. Community meetings were also held to provide information on availability of health services and resources. Women would come to a health-worker, who would then take a detailed health-story and after examination, suggest healing measures or other relevant advice. Each case was recorded and followed up.

Initial Testing of Herbs

Initially, the health-workers began with treating simple ailments like aches and pain, headaches, indigestion, nausea and vomiting, acidity and so on. After building rapport with women, they were able to move on to genital tract ailments, like *garmi* (heat in the body), burning in the urinary tract, vaginal infections and menstruation problems.

Shodhini collectively finalised the criteria to be used for selecting the herbal remedy that would provide relief from a particular ailment. The remedy should be:

- used in more than one field area;
- locally available, acceptable and used;
- non-toxic and likely to provide relief ;
- used with minimal or no accessory herbs or materials;
- simple to prepare and easy to apply.

Health-workers were also provided with workable, standardised dosage guidelines with the help of a *vaidya* in the team (see Table 14.3).

The duration of treatment and follow-up guidelines were also standardised in keeping with the situation. For example, in menstrual cycle complaints, the herb was first to be taken for one cycle. If the patient showed improvement, it would be continued for the next two cycles. If not, the patient's history would be once again reviewed in detail. Then either the recipe would be modified or the health-worker might refer the patient to the nearest government hospital or private practitioner. Similarly,

Table 14.3
Dosage Guidelines

Part or Preparation of the Herb	Measurement
Stem, roots	One index finger length
Bark	Area covered by all four fingers
Flowers, fruits, leaves	Number
Decoction	1:3 of pounded herb and water, boiled till reduced to 1/3 rd quantity
Powder	Teaspoonfuls
Preparing medicated oil	1:4 of oil and herbal decoction with equal quantity of herb
Juice	Pound a handful of herb; use a thin cloth to extract juice.

guidelines were developed for other complaints as well, such as heavy vaginal secretions of varying characteristics.

During the patient's first visit, the health-worker would fill in the record or case sheet after prescribing the medication and directions for use. During the second and third visits, usually after one and two months respectively, follow-up information related to the herb's use, improvement or worsening of patient's condition, and appearance of other ailments, if any, would be recorded. If possible, an examination would also be done. Follow-up would be stopped after three months. Later, the follow-up routine was modified to suit the nature of illness. The case sheets would be scrutinised at every self-help session of the health-workers groups, and all essential information extracted. Shodhini collected 200 such record sheets through this process. Through this initial trial process, 30 herbs useful in 15 common gynaecological conditions were identified. In addition, 13 other herbs were found to have useful antispasmodic, antiseptic, anti-inflammatory, nutritive and immunity-promoting properties.

Extensive Documentation 1993-1997: Emerging Concerns

Shodhini researchers collectively documented their experience in a document that went through various drafts in response to numerous experts' comments and suggestions. In May 1997, their book *Touch-me, Touch-me-not — Women, Plants and Healing* was published by Kali for Women, New Delhi. This effort, which empowered women to find their own solutions to their health problems, was the first of its kind in India. Through it, rural women started identifying and addressing their own health problems and women healers gained some measure of much-deserved recognition. By undertaking this effort, Shodhini successfully explored a path away from the 'mainstream' paradigm of medicine and research, stepping into the domain of 'appropriate holistic health and development'. Certain specific issues emerged out of this process.

Herbs and their Usage

While most women have been using herbs for treating their own health problems, little was known about their effectiveness, particularly for relieving or curing gynaecological ailments. The dominant health care system relies largely on antibiotics, hormones and other drugs that are hardly accessible to most women. In this effort local herbs were successfully used to bring relief from common gynaecological complaints.

Self-esteem of Women Healers

It is ironic that while the world has gradually begun to value health systems other than allopathy, many of the people and communities who are bearers of this alternative knowledge are losing interest in it. Societal values, particularly in India, make women even more prone to discount the worth of their skills and knowledge. The Shodhini investigation provided an insight into the wealth of information that still exists at local levels, and it opened the doors for further exploration. However, the process was not easy. The first hurdle to be overcome was the low value that women healers attributed to themselves. They saw their healing practices as part of their day-to-day lives, and therefore not worth talking about. In any case, no one had shown much interest in them before Shodhini. It was

Table 14.4
Evaluative Compilation of Plants

Herb's Name and Part Used	Problem	Regions of Usage	Total No. of Users (Women)	Comments
<i>Allium sativum</i> (garlic cloves)	Yellow vaginal discharge caused by trichomonas infection	Andhra, Delhi Gujarat and Karnataka	38	Works well, but male partner also needs treatment
„	Back pain	Andhra and Karnataka	21	Consume orally until infection is cleared fully and apply externally with oil
„	Stomach pain due to flatulence	Andhra and Tamil Nadu	27	Works well, especially in pain associated with acidity
<i>Asparagus racemosus</i> (Shatavari) (root)	Non-specific vaginal infection	U.P., Karnataka Andhra and Gujarat	37	Is cooling and a tonic, cures infection resulting from weakness and low resistance
„	Weakness, anaemia leading to heavy bleeding in menstruation	Karnataka and Tamil Nadu	42	Is cooling and a tonic, cures infection resulting from weakness and low resistance
<i>Azadirachta indica</i> (Neem)	Chronic vaginal infection	Andhra and Gujarat	41	Very effective; is an antiseptic and a blood purifier
<i>Mimosa pudica</i> (Touch-me-not) (full plant)	Heavy and/or irregular bleeding	Karnataka and Andhra	28	Especially for heavy bleeding associated with weakness and fatigue
„	Painful periods	Tamil Nadu, Karnataka and Andhra	38	Very effective

Table 14.4 (contd.)

„	Non-specific vaginal infection promoter	Karnataka and Tamil Nadu	23	Works as an immunity promoter
„	Body pain, fever	Karnataka and Tamil Nadu	35	Works as an immunity promoter
<i>Phyllanthus emblica</i> (Indian gooseberry) (fruit)	Chronic vaginal infection	Tamil Nadu, Andhra and Karnataka	28	Works well, has healing and body-building powers
„	Anaemia and weakness	Tamil Nadu, Andhra and Karnataka	31	Works well, has healing and body-building powers
„	Heavy bleeding during periods due to anaemia	Tamil Nadu, Andhra and Karnataka	11	Works well, has healing and body-building powers

Source: Excerpted from Index II; *Touch me, Touch-me-not*.

only after a series of meetings and persistent exploration that the Shodhini team could gather even the initial, basic information.

Communities showed the same sort of attitude towards the use of herbs – since they were there, part of their everyday lives, they were not valued much. However, after some positive experiences, their use became popular among both women and men.

Identification and Collection of Herbs

Many available herbs were commonly known and had the same names as in the formal systems (*neem*, *ajwain*, *giloe*, garlic, etc.). Others had different local names but were easily identifiable with the help of Ayurveda and other literature (*kalo velo* or Indian sarsaparilla). A small range of locally named and used herbs was not identifiable by Sanskrit or botanical names. Although these were not included in the study, they nevertheless

need to be identified.

Standardisation of Dosage

Through their experience and insight, most healers used arbitrary measurements and dosages, depending on the state and constitution of their client. In the Shodhini effort, the quantities suggested were weighed and compared, and workable herbal regimens formulated. Thus, 'standardised' guidelines were evolved for use at field level. However, the process was not easy or problem-free, particularly when herbs that were not referenced for the same symptoms were tested. In such situations, a wait-and-watch approach was adopted, and standardisation was done after a few applications. Women healers were not used to a standardised treatment regime, but after frequent training and rigorous follow-up, most of them were able to appreciate the logic behind such standardisation.

Interfacing of Terminologies, Frameworks, Concepts and Systems

Another problem was the interfacing of terminologies, frameworks, and mindsets. Initially, the approach for gathering information on menstrual pain, heavy bleeding and vaginal infection, etc., relied on an allopathic framework. But this made little sense to the healers as their concepts and terminologies were different. For example, painful periods were known as *maasik ma balatra* in Panchamahals, which literally means burning during periods; to remedy this, cooling herbs were often prescribed. This, however, would be contraindicated in the Ayurvedic system, which would recommend *ushna veerya* (heating property) herbs and regimen to regulate the functioning of *apaan vaayu*, the causative factor of many of women's diseases (*striroga*). In such situations, it was decided to go by what the informant reported was locally prescribed, at a 'no risk' basis. At times, healers resorted to a combination of natural healing and allopathic concepts. For example, suggesting cooling preparations that showed estrogen-like properties, like fennel and rock-sugar.

Similarly, in case of *garmi* (a common condition of 'too much body heat'), a neat understanding from the allopathic perspective was not possible. However, Ayurveda helps to understand this in terms of increase in

pitta and would suggest cooling herbs, food items, activities and thoughts.

A similar interweaving of congruence and contradiction was encountered in the use of herbs. According to Ayurveda, some of the herbs that women use would be contraindicated for that condition due to their properties. For example, both *Tinospora* and *Adhatoda*, used locally in heavy bleeding, are *ushna veerya*, or of heat-producing nature and would be expected to increase bleeding. Similarly, some herbs known to be effective for a particular condition were found useful for a different condition. An example was the use of *Mimosa pudica* (*stambhak* - astringent) in heavy bleeding. Further, *safed pani* (white or watery vaginal secretions) is traditionally treated by oral remedies. Shodhini recommended local applications in the woman's vagina, based on allopathic practice. For example, a *neem*-paste tampon is recommended in cases of yellowish secretion, based on *neem's krimighna* (anti-germ) properties. In both cases, since the causative factor is heat-producing diet and activities, avoiding those and eating cooling food, etc., was prescribed, along with treatment for the male partner as well. The plural system approach adopted by Shodhini has been of help in this situation. It reinforces the need for a more sensitive interfacing and partnership between various systems of healing.

Validating Traditional Knowledge

Shodhini evolved a set of tentative, workable criteria for assessing the efficacy of herbs. The process involved three stages of preliminary inquiry before designating a plant as substance for further investigation by action research:

- The plant should be used in more than one field area of the study and for the same symptoms.
- Traditional use of the plant would be examined in the light of existing phyto-chemical (botanical) and Ayurvedic knowledge. If the botanist and *vaidya* in the team could verify that this was consistent, it would pass the second stage of the inquiry.
- Confirming whether the use of a plant in women with similar symptoms within a community resulted in relief from the symptoms

and eventually in cure of the illness.

Only when such confirmation was available from a numerically significant number of cases would the claim about the plant's prowess at curing a particular ailment be accepted as valid. This three-tier methodology proved useful to validate herbal knowledge to quite an extent.

Limitations

In this action-research undertaken at multiple sites with local women in their communities, the Shodhini collective did not adopt double-blind methods that are frequently part of modern medical research studies. On the contrary, the approach emphasised active participation by the healer and patient, with both women possessing full knowledge of what remedy was being prescribed and consciously observing whether it was working or not. While Shodhini was committed to this approach, it was not blind to its limitations. For instance, biases could not be ruled out. Also, it is sometimes difficult to conclude whether it is the herb that has worked and not emotional factors or the self-curing course of an illness. All in all, however, it was seen that quite a number of women suffering from chronic complaints had tried several other measures without much relief before they entered into this treatment.

Shodhini undertook this effort especially to address common gynaecological ailments faced by women at a primary health care level. Some other common ailments of women were also addressed. However, from what the women themselves say, there is an urgent need to look at herbal alternatives useful for contraception, abortion, nutrition and STDs – a need that remains unmet.

Conclusion

Through the Shodhini effort groups of rural women in several parts of India managed to identify and address some of their most common ailments using locally available herbs. It enabled women to explore their own concepts of the body and of healing itself. The approach

was holistic in that it considered not only their use of local herbs, but also their food, their burden of work, their particular worries and the pressures of society on them. It re-connected the participant women to their local realities and threatened resources in a new way. Shodhini's experience also confirmed that we must view and deal with women's health within the socio-economic and cultural context of communities.

Based on these experiences it is recommended:

1. That a model such as Shodhini be replicated and integrated in the Reproductive and Child Health (RCH) Programme. This training could be given to Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs) and Male Health-workers (MHWs) to provide RH services in rural, remote areas. Alternatively, local women and healers with some literacy skills and experience could be trained to provide RH service. The primary health centres (PHC) and subcentres could play a role in training, guidance and support.
2. That the government increase its investment in Indian systems of medicine and Homeopathy. They need to be strengthened and also motivated to provide RH services based on time-tested principles and practices. Linkages need to be made with the local indigenous healers within the primary health system.
3. That, in the Government of India's planned scheme of herbal nurseries, herbs useful for primary health care and women's health be grown and used by the local communities.
4. That action-research of this nature be initiated on other RH aspects, particularly contraception, abortion, anaemia, sexually transmitted infections, infertility, fibroids, menopause and so on.

Chapter 15

**WAH! Perspectives on
Traditional Systems of Medicine**
Focus on Women's Health

G. G. Gangadharan, Philomena Vincent and Mira Sadgopal

'... to ensure primary health care that is women-sensitive and comprehensive throughout the life cycle through empowerment of women and communities, drawing upon local health traditions and practice' (WAH! Approach Document 1997).

Supporting Traditional Systems of Medicine (TSM), especially local health traditions, is one of the three foundational 'pillars' of the WAH! (Women and Health) Programme. Traditional medicine is stressed because, in the form of local health and healing practices, it is close to women. It is not only accessible but also understandable, affordable and effective. Despite such advantages, recent changes in the global economy and the aggressiveness of Western medicine threaten to snuff out traditional healing systems and the ways of life that have developed over thousands of years. Unfortunately, this is a trend common to all countries that have surviving indigenous populations, with governments doing little or nothing to reverse the trend. People belonging to local communities – especially women, who have passed on health and healing traditions for countless generations

– are being systematically marginalised. Thus, as a part of women's empowerment, of building health services, and of appropriate community development programmes, it is important to validate, preserve and promote TSM.

TSM in Primary Health Care

At a Working Group Meeting held after the historic Alma Ata Declaration of 1978, World Health Organisation (WHO) experts arrived at the following definition of TSM:

‘Traditional medicine is the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing.’

Traditional medicine is still practised and accepted by communities as part of people's culture and heritage. It should therefore be promoted and its potential developed for wider use and benefit, beginning with the primary health care level.

In India, TSM has developed within an ambience of mega-biodiversity. According to the government's *All-India Ethno-Botanical Survey*, part of the Man and Biosphere Programme under the Ministry of Environment and Forests, over 8,000 of more than 25,000 species of higher plants, are medicinally used by 441 ethnic communities in the country. Of these, around 2,500 find reference in various classical texts of TSM. The WHO acknowledges that TSM is used to address over 70 per cent of the country's health care needs

- by about 4,00,000 registered practitioners of Indigenous Systems of Medicine (ISM): Ayurveda, Unani, Siddha, Tibetan (Amchi), Yoga, Naturopathy, etc.;
- by over 6,00,000 traditional birth attendants (*dais*);
- by over 60,000 indigenous bonesetters;

- by thousands of local specialists in traditions such as *netrachikitsa* (treatment of eye conditions) and *vishachikitsa* (healing of poisonous bites); and
- by countless unregistered folk healers and millions of women and men treating common ailments in their homes and neighbourhoods.

A study of local health traditions conducted by the Academy of Development Sciences (ADS 1990) in Raigad District of Maharashtra reveals that ordinary village women know how to manage more than 50 common health problems using local resources and home remedies. Similar findings have emerged from other studies conducted by Aikya (1996) in Chikamagalur District, Karnataka, by Stree Sangshema Trust (SST 1998) in Anantpur District of Andhra Pradesh, from the multi-regional action-research experience of the Shodhini Collective (1997), and from the multi-state Study of Women and Child Health Traditions conducted by Lok Swaasthya Parampara Samvaddhan Samiti (LSPSS 1995).

In short, TSM (Boxes 15.1 and 15.2) is valuable in primary health care as it is

- culturally in tune with local communities;
- related to local resources, food habits, lifestyle and environment;
- promotive, preventive and curative (or, health-sustaining and healing);
- decentralised, self-reliant and empowering; and
- cost-effective and sustainable.

The Government's Position

In the Ninth Five Year Plan, government support for TSM is meagre and vague. It fails to provide for any linkage between TSM and so-called 'mainstream medicine' in our National Health Services. For instance, only 3 per cent of the current National Health Budget is allotted to TSM in its allocation for achieving health care coverage of our population. Surprisingly, though the 1983 National Health Policy (NHP) was never really implemented, that document does recognise the key role potential of TSM in health care:

Box 15.1**The Two Streams of Traditional Medicine**

Traditional Systems of Medicine (TSM) flow through two distinct but mutually nourishing streams – an informal, oral stream of Local Health Traditions (LHT) and a formal, codified stream represented by the classical Indigenous/Indian Systems of Medicine (ISM). Thus, LHT + ISM = TSM.

- The LHT stream (also known as 'people's health traditions' or *lok swasthya parampara*) springs from the experiences of thousands of communities in diverse geographical zones and local cultures, evolved over uncounted millennia. This stream is basically ecosystem-specific, suits local needs and depends on immediately available resources such as flora, fauna and minerals. Spread over six lakh villages across India, LHTs are carried by village midwives (*dais*), bonesetters and other local healers, including ordinary villagers and among them, particularly women.
- The systems of the ISM stream are codified in thousands of manuscripts and classic texts representing the Ayurveda (linked with Yoga), Siddha and Unani (Indian Greco-Arabic) traditions, and also the Tibetan tradition practised in India. All these have their own history, a unique underlying set of principles and worldview of health and life phenomena. Practitioners (*vaidya*, *hakim*, etc.) are classically educated through years of rigorous training under the guidance of senior ISM physicians (*guru-shishya* tradition).

The codified and oral streams have been interacting for thousands of years, so that many practical aspects of ISM are drawn from LHT. When validated, the oral traditions are found largely consistent with principles and concepts in ISM; for instance, in Ayurveda, the concepts of heating and cooling effects (*ushna*, *sheeta*) and the constitutional principles *vaata*, *pitha* and *kapha*. Similar parallels may be found between the LHTs in regions influenced by Muslim cultures and the formal Unani *system*.

Thus, TSM as a whole rests on specific and ancient holistic views of health, life and the environment.

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Box 15.2**Basic Principles of ISM: Example of Ayurveda**

According to Ayurveda (*ayur* = life, *veda* = knowledge), the whole world – including living beings and inert substances – is made up of five elements (*pancha-mahabhoota*). Their infinite and reversible permutations and combinations create objects or 'beings' of diverse constitutions. Thus, in everything that has existence in consciousness, these five elements are present:

prithvi (earth, or solidity principle)

aapa or *jala* (water, or fluidity principle)

tejas or *agni* (fire, or heat principle)

vaayu (air/wind, or movement principle)

aakaasha (ether, or space principle).

In living beings, the *pancha-mahaabhoota* are re-grouped into three dynamic constitutional elements of *vaata*, *pitha* and *kapha*:

vaata is mostly *vaayu* combined with *aakaasha*, and less of the other three principles,

pitha is mostly *agni* and less *jala*, with a little of the other three principles, and

kapha is *prithvi* + *jala* combined, with less of the other three principles.

The role of the physician (*vaidya*) or healer is to observe changes (or vitiation) in these three body elements, either alone or in combination. He then has to provide the right substances from the outer universe to restore the equilibrium, processing the substances into forms of medication (*aushadhi*) that the body can assimilate. Another function of the healer is to advise appropriate lifestyle measures (*pathya*) of diet, exercise or rest, in order to help the body in deranged condition regain its internal environmental balance. It is from this viewpoint that the physician Vaagbhata described everything in the universe as medicinal ('*jagathyevama noushadham navadya*'). Understood from an inclusive perspective, TSM will be found to hold considerable preventive, promotive and curative potential for primary health care.

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'The country has a large stock of health manpower comprising of private practitioners in various systems, for example, Ayurveda, Unani, Siddha, Homeopathy, Yoga, Naturopathy, etc. This resource has not so far been adequately utilised. The practitioners of these various systems enjoy high local acceptance and exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned efforts should be made to dovetail with the functioning of the practitioners of these various systems and integrate their services at the appropriate levels within specified areas of responsibility and functioning in the overall health care delivery system, especially in regard to the preventive and promotive public health objectives. Well-considered steps would also require to be launched to move towards a meaningful phased integration of the indigenous and modern systems' (GOI National Health Policy 1983).

Thus, the relevant NHP aims were:

- To utilise the vast TSM resources;
- To enable each TSM to develop appropriately; and
- To integrate TSM services in the overall health care system.

Although the comprehensive NHP document was passed in Parliament in 1983, it was replaced by numerous vertical policies and programmes that are still in operation, including some new ones. At the same time, there has been a further shift towards 'curative' Western medical care rather than in the direction of 'preventive' or health-promoting solutions. Consequently, indigenous systems – encompassing preventive, promotive and curative health care – have been marginalised. In view of this, and also of the rising costs of drug/technology-dependent medicare, the option of reviving local health traditions to deal cost effectively and safely with most common health problems at the community level is logical.

The health section of the Approach Paper to the Tenth Five Year Plan emphasises the

‘... reorganisation and restructuring of existing health infrastructure, including the infrastructure for delivering ISM&H services, at primary, secondary and tertiary levels, so that they have the responsibility of serving populations residing in a well defined geographical area and have appropriate referral linkages with each other.’

Section 3.69 in the Approach Paper states that:

‘There are six lakh practitioners in Indian Systems of Medicine and Homeopathy in the country. They will be provided with appropriate orientation/skill upgradation through Continuing Medical Education programmes, mainstreamed and utilised in improving access to health care coverage under the national programmes. Efforts will be made to fully implement the recommendations of the Planning Commission’s Task Force on preservation, promotion and cultivation of medicinal plants and herbs, ensure availability of good quality ISM&H drugs at affordable prices within the country and fully realise the export potential for these drugs and formulations.’

Recent Policy Initiatives

In the year 2001, the Ministry of Health and Family Welfare came up with two health policy initiatives – the Draft National Health Policy 2001 and the Draft National ISM Policy 2001. To some extent, these initiatives do reflect the reality of changes – both in health status (falling sex ratios, spreading pollution, rising violence, and the teetering health status of women, children and others), and in the ‘demand’ for Indian medical services and products (both allopathic and traditional). Both of these developments are largely linked to the trend of economic privatisation and globalisation.

In the National Health Policy 2001, ‘Alternative Systems of Medicine’ (Ayurveda, Unani, Siddha and Homeopathy) have been recognised for

making a significant 'supplemental contribution to health care services', particularly in under-served, remote and tribal areas in the country. While a separate policy document has been specified, the 'main components of NHP 2001 apply equally' to these systems (Section 2.26, NHP 2001).

The Draft National ISM Policy begins by recognising the paradox that, while the country's vast unmet need of PHC services cries out for notice, there exist widely used 'Indian Systems of Medicine' that are embedded in the diverse customs of a very large section of the public. But while the Draft ISM Policy identifies key issues and areas, it leaves the goals for achievement unspecified. And while the NHP 2001 *does* spell out health goals to be achieved by 2005 to 2015, there is no linkage or even mention of these in the Draft ISM Policy. This is despite the statement that the 'main components of the NHP 2001 apply equally to the alternative systems of medicine' (Section 2.26, NHP 2001).

Articulation of goals is important not only for clear interpretation of policy and assessment of implementation effectiveness but also for promoting the government's accountability, of which the accomplishment of the avowed goals would be a measure (see Chapter 22 for a critique of the Draft ISM Policy).

Recommendations for Policy Change and Programme Strategies

Based on our field experience and our discussion in the preceding paragraphs, we make the following recommendations for incorporating TSM within the National Health Policy, especially in the context of women's health (see Table 15.1):

Table 15.1
Recommendations for Policy Change
and Programme Strategies

Areas of Concern	Practical Steps
Official recognition of practitioners and health-workers in the Traditional Systems of Medicine.	Find ways to recognise and use local expertise and experience available with traditional practitioners. For example, the government might consider instating a graded registration system for TSM practitioners (A = graduates, B = diploma holders, C = recognised local healers, with specific roles).
Evaluation of TSM approach, skills and therapies.	Evaluate TSM therapeutic frames in order to select approaches and therapeutic measures that can be easily and economically adopted for wider public use.
Mainstream orientation programmes for TSM practitioners - specific using their own knowledge and	Instate orientation programmes for registered TSM practitioners to involve them in the mainstream health programmes, resources.
Public education (and demystification) about TSM.	Educate the public about the role and value of TSM in promoting and sustaining health, and to break the myths and misinformation spread by vested interests.
Acknowledgement of TSM in shift of research priorities and methodologies.	Bring about a shift in research priorities and methodologies acknowledging the foundational principles and worldview of TSM so that it can contribute to the world of medicine.
Protection and conservation of medicinal plants and health practices.	Build and maintain local databases of medicinal plants and practices used in TSM; disseminate this information appropriately for use by communities, schools, practitioners and researchers.
	Restrict the indiscriminate use of medicinal plants by industry.
	Stop multinational companies and other vested interests from appropriating our traditional knowledge and resources.

Table 15.1 (contd.)

Promotion of wider utilisation of ISM formulations.	Use state resources to promote production and marketing of researched and evaluated TSM medicines.
	Make available TSM remedies in simple, locally packaged form for public and primary health care systems.
TSM in Primary Health Care and women's health.	Enlarge budget allocations for contribution of TSM to PHC and RCH, for medicinal plant cultivation and conservation, for public health education, for support of the local healing community including midwives, and for R&D.
	<p>Change PHC infrastructure and orientation to suit and allow TSM to contribute, such as:</p> <ul style="list-style-type: none"> · Provision for small demonstration herbal garden with plants of importance in common ailments. · A small pharmacy to make and stock simple decoctions and other formulations. · A therapeutic assistant to conduct various therapeutics as per TSM both at Out Patient/In Patient level
Medical and health professional education.	Integrate PHC and RCH with gender-sensitive approach into undergraduate ISM courses.
	Sensitise mainstream medical education to the strengths of ISM/TSM for PHC and RCH.
	Develop appropriate curricula for training nurses and ANMs, technicians, pharmacists, etc.
Interfacing of TSM and Allopathic Systems	Work out principles and logistics of interfacing allopathy with ISM/TSM in PHC and RCH.

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Section III

Policies and Programmes



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*Chapter 16***Current Policy Scenario in India**Abhijit Das¹

Ever since its inception, successive Five Year Plans have served as the blueprint for India's growth and development. The Tenth Five Year Plan (2002-2007) is the first such plan of the new millennium. While the new plan promises high economic growth (8 per cent), it also acknowledges that social development does not necessarily follow economic growth. The role of women as agents of socio-economic change was acknowledged in the Ninth Five Year Plan itself, but in the absence of targets that could be effectively monitored, the progress was not in line with expectations.

The Approach Paper to the Tenth Five Year Plan clearly acknowledges that side by side with economic development, enhancement of human well being is a national priority that needs to be emphasised. It further states that this well being is not just limited to consumption of food but also access to basic social services, especially in education, health, availability of drinking water and basic sanitation. There is a concern for disparities between individuals and groups and between states. There is a commitment to increasing the participation of marginalised sections of society in

decision-making. Women have been clearly identified as the most vulnerable group in this regard. (See Table 16.1 for a statistical profile of women in India). There is also a promise to increase allocation of resources for the social sector without which much of these concerns will remain in the realm of wishful thinking. The approach paper lays down 11 monitorable targets for the Tenth Plan and beyond and it makes its commitment clear by relating at least seven of these to social sector development.

The 1990s have been a decade of change and of promise. On the one hand, far-reaching economic changes were ushered in within the country, while in the social sector there were a few international conferences that promised to change the subordinate situation of women. Two significant conferences in this regard were the International Conference on Population and Development (Cairo 1994) and the Fourth World Conference on Women (Beijing 1995). India was a signatory to the operational plan of the two agreements that emerged from these. The Ninth Five Year Plan (1997-2002) adopted the strategy of empowering women as agents of socio-economic change and development. In this context, two very significant policy initiatives have been taken — the National Population Policy (2000) and the National Policy for the Empowerment of Women (2001); the draft of a third policy (National Health Policy 2001) is being discussed. All three policies have devoted special attention to the needs of women.

International Commitments

The International Conference on Population Development (ICPD) Programme of Action (PoA) clearly spelt out that human beings have to be at the centre of concern for population and development. It further clarified that advancing gender equality and equity and the empowerment of women, elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. It urged different countries to take all appropriate measures to ensure,

on a basis of equality between men and women, universal access to health care services, including those related to reproductive health care that covers family planning and sexual health.

While acknowledging the links between poverty and population, the conference agreed that slowing population growth, reduction of poverty, economic progress, improvement in the environment, and reduction in unsustainable consumption and production patterns are mutually reinforcing. It clearly noted that eradicating poverty would contribute to slowing population growth and achieving early population stabilisation, rather than vice versa. Women were acknowledged as the poorest of the poor but also as key actors in the development process. The ICPD PoA urges governments to increase the ambit of population and development programmes to include concerns of the girl child, the adolescent, the elderly, to involve men, to focus on the special needs of indigenous people, migrants and displaced persons in addition to regular Sexual and Reproductive Health and Rights programmes. It also urges governments to increase resource allocation for these programmes.

The Platform for Action (PfA) of the Fourth World Conference on Women (FWCW) focuses on concerns around women's health. Women's health is defined to include their emotional, social and physical well being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well being elude the majority of women. A major barrier that women face in the achievement of the highest attainable standard of health is inequality. The PfA advises governments that in addressing inequalities between men and women in terms of health status and unequal access to and inadequate health care services, an active and visible policy of mainstreaming a gender perspective in all policies and programmes should be promoted. Also, before decisions are taken, an analysis should be made of the effects for women and men respectively. In specific terms, the PfA recommends that

- there must be an increase in women's access throughout the life cycle to appropriate, affordable and quality health care,

information and related services.

- preventive programmes that promote women's health must be strengthened.
- gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues must be undertaken.
- research and dissemination of information on women's health must be promoted.
- resource allocation for women's health must increase.

Concern for the rising incidence of violence against women is common to both documents and both documents urge governments to address this issue as part of their population and health programmes.

The Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) was also ratified by India in 1993. This Convention is the only human rights treaty that affirms the reproductive rights of women. As a part of the commitment to this Convention, governments agree to take all appropriate measures, including legislation and temporary special measures, so that women can enjoy all their human rights and fundamental freedoms. As a country that has ratified this convention, India is committed to reduce and eliminate all forms of discrimination against women through policy, programme as well as legislative initiatives.

National Initiatives

The National Population Policy (NPP) 2000

The National Population Policy (NPP) 2000 provides an analysis for the high population growth rate, highlighting four factors, namely, the demographic momentum of young people and earlier age groups in childbearing, the high infant mortality rates (IMR), and the high level of unmet need due to poor access to services and the low age at marriage prevalent in many parts of the country. Among its 12

strategies for action the NPP 2000 calls for

- decentralisation in planning and implementation,
- convergence of services delivery,
- empowerment of women for health and nutrition, and
- meeting unmet needs through improved service delivery.

There are 14 national socio-demographic goals set for the year 2010 in the Action Plan of NPP 2000. These goals pertain to several important aspects and areas of maternal and child health as well as to socially critical issues, such as promotion of delayed marriage for girls and universal registration of marriages as well as institutional improvements like intersectoral coordination and convergence in social sector. The Action Plan gives high priority to the expansion of the availability of safe abortion care for which several operational strategies have been spelt out.

National Health Policy (NHP) 2001

The draft National Health Policy (NHP) 2001 sums up the macro situation in the health sector as follows:

1. The morbidity and mortality levels in the country are still unacceptably high. The public health system has had limited success in meeting the preventive and curative requirements of the general population. The state investment in public health is declining. There has been an epidemiological shift in the disease pattern, in which both the new lifestyle diseases and the old communicable diseases have to be countered.
2. Although balanced regional development was one the objectives of centralized planning, attainment of health indices has been very uneven across the rural-urban divide, and between better-endowed and more vulnerable sections of society. There are vast differences between some states and others. For vulnerable sections of the society, access to public health services is nominal and health standards are grossly inadequate. Even here, the gender divide is acutely striking. Across the board, women and

children both suffer from poor access to and benefits from the public health system throughout the country.

It is an expressed aim of the draft NHP 2001 to reduce these inequities and enable the disadvantaged sectors of society to get fairer access to public health services.

National Policy for Empowerment of Women (NWEF) 2001

The National Policy for Empowerment of Women (NWEF) 2001 includes among its objectives

- the enjoyment of all human rights and fundamental freedoms by women on an equal basis with men in all spheres – political, economic, social, cultural and civil;
- equal access to participation and decision-making by women in the social, political and economic life of the nation;
- equal access of women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office;
- changing societal attitudes and community practices by active participation and involvement of both men and women;
- elimination of discrimination and all forms of violence against women and the girl child; and
- mainstreaming a gender perspective in the development process.

Among its policy prescriptions it suggests that a holistic approach to women's health, which includes both nutrition and health services, be adopted and special attention be given to the needs of women and girls at all stages of the life cycle. The reduction of infant mortality and maternal mortality, which are sensitive indicators of human development, is a priority concern. Women should have access to comprehensive, affordable and quality health care. Measures will be adopted that take into account the reproductive rights of women to enable them to exercise informed choices, their vulnerability to sexual and health problems together with endemic, infectious and

communicable diseases such as malaria, TB, waterborne diseases as well as hypertension and cardio-pulmonary diseases. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases will be tackled from a gender perspective. The policy also goes on to commit that to effectively meet the problems of early marriage and infant and maternal mortality, the availability of good and accurate micro-level data on deaths, births and marriages is required. Strict implementation of registration of births and deaths would be ensured and registration of marriages would be made compulsory.

All three policies echo a common concern around the need to stabilise population at a level consistent with the requirements of the national economy. The National Health Policy (draft) 2001 has argued, 'Attainment of improved health indices would be significantly dependent on population stabilisation,' and 'Unless the population stabilisation goals are achieved, no amount of effort in the other components of the public health sector can bring about significantly better national health standards.' The NPEW 2001 takes on board the commitment to population stabilisation contained in the NPP 2000.

The NPP 2000 speaks in detail of decentralised planning and programme implementation in the area of reproductive and child health (RCH). The involvement of the Panchayats in health and family welfare activities is recommended in all three policy statements. The NPP 2000 links decentralisation with the convergence of the national family welfare programme with ICDS, without which, it argues, decentralisation will be meaningless. The NPEW 2001 recommends all-women institutions be set up from the grassroots level upwards to bring out synergistic implementation of economic and social programmes by drawing resources from state and NGO sources. For instance, self-help groups (SHGs) will form at anganwadi level and federate at Panchayat and municipal level.

All three policies advocate the integration and use of indigenous systems of medicine to increase the outreach of health services. The NPEW 2001 explicitly recommends its enhancement within the

Table 16.1
Women in India – A Statistical Profile

		Source
Sex ratio (females to males)		Census 2001
Total population	933:1000	
0-6 years	927:1000	
7 years and above	935:1000	
Life expectancy at birth (years)	59.7	VHAI 2000
Infant mortality rate	68 per 1000 live births	NFHS 2, 1998-99
Under 5 mortality rate	95 per 1000 live births	- do -
Maternal mortality ratio	540 per 100,000 live births	- do -
Pregnancy care received (percent)		- do -
Antenatal check-up from a health professional	65	- do -
Antenatal check-up in first trimester	33	
Two or more tetanus toxoid injections	67	
Iron and folic acid tablets or syrup	58	
Percent of deliveries assisted by		- do -
Doctor	30	
Trained nurse/midwife	11	
Traditional birth attendant	35	
Percent of women with anaemia	52	- do -
Total fertility rate	2.85 births per woman	- do -
Singulate mean age at first marriage	19.4 years	VHAI 2000
Median age at first birth among women age 20-49	19.6 years	- do -
Mean ideal number of children	2.7	- do -
Percent currently using a modern contraceptive method	43	- do -
Female sterilisation	34	
Condom	3	
Pill	2	
IUD	2	
Male sterilisation	2	

Table 16.1 (contd.)

Percent currently using a traditional contraceptive method	5	- do -
Percent with unmet need for Family Planning	16	- do -
Percent with unmet need for spacing	8	- do -
Percent reporting at least one reproductive health problem	39	- do -
Percent did not seek treatment	66	- do -
Percent aware about HIV/AIDS	40	- do -
Percent reporting domestic violence	20	- do -
Percent literate (+15 years)		Census 2001
Total	65	
Male	76	
Female	54	
Percent households headed by women	9	
Percent economically active (ages 15+)		VHAI
Rural	38	
Urban	18	
Organised sector	16	
Unorganised sector	34	
Percent of women economically active (ages 10-11)		- do -
Rural	14	
Urban	5	
Percent of women involved in decisions about own health	52	NFHS 2, 1998-99
Percent of women with control over some money	60	NFHS 2, 1998-99
Percent women in political office		VHAI
Parliament Lower House	7	
Upper house	9	
Gender Development Index Rank	105	UNDP
Gender Development Index Value	0.553	- do -

framework of health available for women. The NPP 2000 recommends these systems in the provision of RCH services, especially in tribal areas. As part of the mainstreaming of indigenous systems, it also advocates the use of barefoot doctors in reaching women, as well as makes provision for their training and orientation.

Analysis of Issues Raised in the Policy Documents

Lack of Priority to Improvement of Women's Overall Health Status

The draft NHP 2001 points out that some of the common features it shares with NPP 2000 that

‘... relate to the prevention and control of communicable diseases, priority to the containment of HIV/AIDS infection, universal immunisation of children ... addressing the unmet needs for basic and reproductive health services and supplementation of infrastructure. The synchronised implementation of these two policies ... will be the very cornerstone of any national structural plan to improve the health standards in the country.’

Improvement of women's overall health status does not find place in this synchronised implementation schema, presumably because meeting women's unmet needs for basic reproductive and health services is assumed to sum up the women's agenda.

Female morbidity and women's disease burden find no place in the description of the current health scenario presented in the first part of the draft NHP 2001. The rising incidence of malaria, TB, problems of drug resistance, HIV/AIDS, the high levels of gastroenteritis, cholera, hepatitis, etc., the emergence of new lifestyle diseases, such as cancer and diabetes, are discussed in terms of mortality and morbidity in the population and in terms of ‘threat’ to public health and ‘economic development’ of the country. However, the differential impact of these on women, some of which have very grave consequences, especially in some stages of women's lives, is not

looked at.

Lack of Attention to Differentials across Groups and Categories

The improvements in the country's health indicators (described in the draft NHP 2001) and its demographic achievements (described in NPP 2000) over the last five decades (i.e., reduction of birth rate, infant mortality rate, death rate, total fertility rate or increase in couple protection rate, life expectancy, etc.) are expressed in national or state averages. Such rounding up does not capture the differentials across the various socio-economic or social categories and sub-groups in the population. However, the draft NHP 2001 has provided in tabular form, a useful comparison of health indices between three 'better performing states' and five 'low performing states' in the country. It has also provided a comparison between the rural and urban areas of the country in terms of health indicators. The NPP 2000 does not disaggregate the national averages, though it does categorise certain spatially defined groups (urban slums, tribal communities, hill population, displaced and migrant populations) as well as adolescents as 'underserved population groups' in terms of access to information and services. But it does not specifically provide any comparisons nor does it differentiate the population by any socio-economic criterion.

Concern for Adverse Sex Ratio is not Uniform

The NPEW 2001 speaks of the declining female-male sex ratio as an instance of gender disparity. It points out to the lower status of women belonging to the Scheduled Castes (SC), Scheduled Tribes (ST), backward classes, minorities as well as women working in the informal or unorganised sector, describing them as 'marginalised, poor and socially excluded'. The policy attempts to go beyond aggregate numbers of women and insist on the availability of good and accurate micro-level data on births, deaths and marriages. The near-consistent decline in the female-male sex ratio over the last century is not discussed either in the NPP 2000 or in the draft NHP 2001, though it is a major demographic change.

Discrimination and Violence: Mixed Messages

The NPEW 2001 speaks of all forms of discrimination against the girl child as a violation of her rights and refers specifically to prenatal sex selection and the practices of female foeticide, female infanticide, child abuse and child prostitution. It makes major commitments to making substantial public investments in the areas of health and nutrition to support the girl child. The NPP 2000 speaks of the girl child in terms of high fertility pattern of 'too early, too frequent and too many' and points to the high percentage of girls (over 50 per cent) who marry below the age of 18. The NPP stresses the enforcement of the Child Marriage Act 1976 to reduce the incidence of teenage pregnancies. There is no reference to girl children or to their health needs in the draft NHP 2001. In fact, there is no discussion on child health anywhere in the text of the document, except for a very brief mention of the long-term risk of chronic morbidity of child labour. Only two indicators of overall child health (infant mortality and low birth weight) are included in the goals listed in the draft NHP 2001 to be achieved by 2015.

The NPEW 2001 commits itself to the elimination of 'violence against women, physical and mental, whether at domestic or societal levels, including those arising from 'customs, traditions or accepted practices', through the creation of institutions and mechanisms for prevention, rehabilitation and punishment. Neither the NPP 2000 nor the draft NHP 2001 takes up the issue of violence against women and girl children. There is no discussion on the links between women's health, women's reproductive health and violence in either of the two documents, nor is there any recognition of the declining female-male sex ratio and the dimension of violence inherent in the increasing incidence of foeticide. The draft NHP 2001 speaks of notifying a new code of ethics to ensure that the common patient is not subjected to irrational or profit-driven medical regimens. But the document provides no space for a discussion on medical ethics and profit making by the medical community arising from the misuse of the Pre-Natal Diagnostic Test (PNDT Act 1994). In fact, this Act does not find mention in either the NPP 2000 or the draft NHP 2001.

Women and Mental Health

The draft NHP 2001 refers to mental health as a disorder seriously affecting the quality of life of affected persons and their families, and frames policy prescriptions to meet the situation in the public health arena through integration with the existing institutions and upgrading of resources. It makes no separate or specific mention of those mental health problems of women, which are more pronounced in some age groups, say, in childbearing women; nor does it outline any strategies to enable and encourage such women to seek professional help. The NPEW 2001 and NPP 2000 make no mention of the mental health problems of women or to their psychosocial impact. Indeed, none of the three documents refers to either the status of implementation or the misuse of the Mental Health Act vis-à-vis women.

Women and Nutrition

The NPEW 2001 singles out the high risk of malnutrition and disease that women face during infancy, childhood, adolescence as well as childbearing years. It speaks of making special efforts to tackle the problem of macro- and micro-nutrient deficiencies, especially amongst pregnant and lactating women, and their link with various other diseases and disabilities. The NPP 2000 recommends coupling family health and nutrition, and the convergence of the ICDS with the programmes of the Department of Health and Family Welfare. The draft NHP 2001 does not make any specific mention of malnutrition, nor does it suggest any policy, strategy or intervention in the nutrition programmes except to term it a 'complementary initiative' from 'the social sector'. The NPEW 2001 brings up the theme of intra-household discrimination in nutrition towards girls and the need to address it through educational strategies.

Concern for Elderly Women

While the NPEW 2001 refers to 'elderly women' as a sub-group of women in difficult circumstances, it makes neither commitment nor reference to their health needs. The NPP 2000 refers to the problems

of the ageing population and to the National Policy on Older Persons (Ministry of Social Justice and Empowerment), but does not refer to the gender aspects of ageing or to the health and reproductive health needs of older women. The draft NHP 2001 makes a brief reference to the increased requirement of geriatric care resulting from increased life expectancy and the need bring changes in the medical syllabus to include geriatric disorders.

Private Sector and Women's Health

The draft NHP 2001 does not discuss the use of private sector health facilities by women, though it puts the figure of aggregate expenditure in the health sector as 5.2 per cent of GDP, out of which the public health spending is put at 20 per cent. The policy highlights the increasing role of the private health sector in secondary and tertiary-level care and speaks of the need for statutory licencing, regulation and monitoring to ensure minimum but adequate standards of diagnostic centres. However, it makes no mention at all of the need to licence and regulate prenatal diagnostic centers.

Intersectoral Linkages

The draft NHP 2001 acknowledges the links between what it calls 'complementary initiatives' and 'non-health determinants' such as rural development, food production, sanitation, drinking water supply, education and public health. But it makes no contribution to defining strategies for ensuring investments in social sectors. Instead, it states that since they fall outside the domain of the health sector, the policy will not address itself to these initiatives. At the same time, it recognises that improved health standards, especially of the girl child, are closely dependent on these sectors.

Efforts for Women's Empowerment Ninth Five Year Plan

The Ninth Five Year Plan acknowledged the importance of addressing women as agents of change and included, as part of its strategies,

- Creating an enabling environment for women to exercise their rights both within and outside their homes.
- Adopting an integrated approach towards empowering women, including the effective use of resources and services.
- Adopting a strategy of Women's Component Plan (WCP) to ensure that fund benefits flow to women.
- According high priority to RCH services.
- Organising women into self-help groups and increasing their access to credit.
- Ensure easy and equal access to education for women and girls.

It was as a result of these strategies that the policies discussed earlier were formulated and the Women's Component Plan was also initiated in some ministries and departments. A review of the plan implementation reveals that many Ministries and Departments were unable to conceptualise women's empowerment. For example, the Ministry of Health and Family Welfare did not think it necessary to formulate a WCP because 70 per cent of the outlay was meant for women. The same was the case with the Department of Law and Justice, the Ministry of Environment and Forests, etc. Even the Ministry of Social Justice and Empowerment had not prepared the plan when the implementation of WCP was undertaken for review in August 2000. This indicates that unless there is a position paper that clearly spells out areas of discrimination and empowerment in the area of jurisdiction related to each Ministry/Department, such component plans will not be successful in facilitating women's empowerment. Though women's cells have been set up in some of these Ministries/Departments, inappropriate deployment and allocation of resources, inadequately formulated schemes, absence of quantifiable targets, inadequate monitoring and poor delivery systems are acknowledged deficiencies in the implementation of the Plan.

Women, Health and Gender

Tenth Five Year Plan Approach Paper

The Approach Paper to the Tenth Five Year Plan (2002-2007) clearly identified some of the deficiencies in social sector achievements. It mentions that despite encouraging progress on many fronts,

‘more than half of the children 1-5 years old in rural areas are undernourished, with girl children suffering even more severe malnutrition. The infant mortality rate has stagnated The decline in juvenile sex ratio ... is an indication that the Constitutional assurance of freedom and equality for women is still far from being fulfilled.’

It promises that the Tenth Plan must ‘halt and reverse such regressive trends, which are rooted in women’s social subordination and ... discrimination’. This incisive analysis is followed by clear targets for social sectors (Box 16.1).

The document defines the major focus of the family welfare programme as improved access of families to health care facilities to enable them to achieve their reproductive goals which, in turn, will help the country to achieve the goals set up in NPP 2000. There is a commitment to provide essential primary health care and emergency and life-saving services in the public domain. The need to improve centre-state and inter-sectoral coordination is also articulated, as is the need for involvement of the voluntary sector, civil society and private sector in these efforts.

In the section on health, there is mention of improving access to and utilisation of health, family welfare and nutrition services by underprivileged and underserved populations. Upgrading of health infrastructure at all levels is emphasised and, in a marked departure from earlier approaches, the horizontal integration of vertical disease control programmes is recommended. Essential primary health care, services under the national disease control programmes and the national family welfare programme will be provided to the poor and underprivileged free of cost or based on the ‘ability to pay, principle,

while user charges will be collected from others’.

Box 16.1

Monitorable Targets for the Tenth Plan and Beyond

- Reduction of poverty ratio by 5 percentage points by 2007 and by 15 percentage points by 2012;
- Providing gainful high-quality employment to the addition to the labour force over the Tenth Plan period;
- All children in school by 2003; all children to complete 5 years of schooling by 2007;
- Reduction of gender gaps in literacy and wage rates by at least 50 per cent by 2007;
- Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 per cent;
- Increase in literacy rate to 75 per cent within the Plan period;
- Reduction of IMR to 45 per 1000 live births by 2007 and to 28 by 2012;
- Reduction of Maternal Mortality Ratio (MMR) to 2 per 1000 live births by 2007 and to 1 by 2012;
- Increase in forest and tree cover to 25 per cent by 2007 and 33 per cent by 2012;
- All villages to have sustained access to potable drinking water within the Plan period;
- Cleaning of major polluted rivers by 2007 and other notified stretches by 2012.

What the document does not consider is how women’s subordinate status affects family size or women’s health, nor does it provide any recommendations for improving the health status of women.

Resource Allocation for Health

The draft NHP 2001 provides a very clear analysis of the resource allocation in the health sector:

‘The public health investment in the country over the years

has been comparatively low, and as a percentage of GDP has declined from 1.3 per cent in 1990 to 0.9 per cent in 1999. ...The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 per cent, while that in the States has declined from 7.0 per cent to 5.5 per cent. ... the contribution of Central resources to overall public health funding has been limited to about 15 per cent. The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget.'

In India, the government's share has been steadily declining and currently stands at less than one-fifth of all health expenditure (Table 16.2). In contrast, data from other countries show that this proportion of public expenditure in health is as high as 96 per cent in the UK, and nearly half in Sri Lanka and the United States. The document also provides recommendations for increasing resource allocation on health:

'The Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities under NHP 2001, it is planned to increase health sector expenditure to 6 per cent of GDP, with 2 per cent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 per cent of the Budget; and, in the second phase, by 2010, to increase it to 8 per cent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 per cent from the existing 15 per cent, by 2010.'

Table 16.2
Plan Outlay in Health and Family Welfare since the First Plan

Period		% of Total Outlay on	
		Health	Family Welfare
First Plan	(1951-56)	3.33	0.01
Second Plan	(1956-61)	3.01	0.05
Third Plan	(1961-66)	2.63	0.29
Annual Plans	(1966-69)	2.12	1.06
Fourth Plan	(1969-74)	2.13	1.80
Fifth Plan	(1974-79)	1.73	1.26
Annual Plan	(1979-80)	2.30	1.00
Sixth Plan	(1980-85)	1.87	1.04
Seventh Plan	(1985-90)	1.88	1.81
Annual Plans	(1990-91 & 1991-92)	1.64	1.32
Eighth Plan	(1992-97)	1.75	1.50

Source: Planning Commission, Department of Family Welfare, Ninth Five Year Plan, 1997-2002, Vol. II, p. 246.

Recommendations for the Tenth Five Year Plan

1. Population growth is affected by a large number of factors, key among them being women's social status and son preference in society. These should be addressed in the Tenth Five Year Plan, in addition to other factors like poverty reduction, economic progress, improvement in environment and reduction in unsustainable consumption and production patterns included in the strategy for population stabilisation. The key role of men in determining family size must be taken into account and strategies outlined for the active involvement of men in the programme. Strategies and programmes for population stabilisation must be situated within a holistic women's health approach. There must be emphasis on family planning services for men and respect for women's reproductive rights and informed choice. Unnecessary and harmful contraceptive technology like long-

acting hormonal contraceptives should not be incorporated into the Family Welfare programme.

2. Concern for women's health should be extended beyond maternal and reproductive health to cover the entire life cycle, and include the health issues of girl children and elderly women. Communicable and lifestyle diseases affect men and women differentially. National disease control programmes must analyse these differences and make specific recommendations for developing interventions for preventing and reducing the incidence of these diseases among women, increasing access to services by women and reducing the impact of these diseases on women. The service delivery system must be made easily accessible to and sensitive to women's needs.
3. Reproductive health programmes must be made more comprehensive by incorporating a life cycle approach. Health needs of adolescents and the elderly must be addressed along with the needs of special groups like the tribals and disabled. Provision of safe abortion services within the public sector must be a priority. Reproductive rights must be incorporated within the reproductive health programmes.
4. While acknowledging that 'privatisation of health care is inevitable in today's world, it is necessary to do a clear analysis of how this will impact women's access to health care services and to develop and incorporate strategies to ensure and enhance the access of poor women to the public health care delivery system.
5. The rural-urban, economic, inter-state differentials and those between different social groups in the context of health and family welfare must be acknowledged at all levels. The needs of the most disadvantaged should be addressed through strategies of preferential resource allocation and differential targets.
6. As the 2001 Census figures of the female-male sex ratio in the 0-6 age group shows, the basic human right for survival has been negated for Indian women as a category. The neat

differentiation between better-performing states and low-performing states in terms of health indicators breaks down when one looks at this ratio across the country. Many of the better-performing states have shockingly low ratios. The higher mortality of Indian females vis-à-vis Indian males in infancy, childhood, adolescence and childbearing years further brings out the systemic biases against women inherent in society. Specific plans and adequate resource allocation must be provided for in the Tenth Plan to halt and reverse this trend.

7. Violence against women must be recognised as an important human right and health concern. Reproductive rights cannot be realised unless the issue of violence against women is effectively addressed. Strategies and plans must be developed to address the issue and adequate resource provision for this is essential.
8. Concern for the girl child should result in plans for her health, nutrition, a life free from violence and early marriage.
9. The role of Indian systems of medicine and the traditional knowledge of women related to healing practices must be acknowledged in the Plan. The role of traditional birth attendants must also be acknowledged and all efforts made to strengthen them.
10. Water supply, sanitation, nutrition, clean environment, shelter and education are powerful determinants of the health status of women. They cannot be termed as just 'complementary initiatives under the developmental umbrella' or 'non-health determinants' and thereby kept outside the scope of discussions on planning and policies on women's health. India spends an unconscionably low amount of public funds on nutrition (0.5 per cent of GNP) and some segments of the population are said to have the highest rates of malnutrition in the world. Strategies must be developed for integrated planning and resource allocation must increase.
11. Decentralisation must form the key principle for planning and plan implementation. In addition to Panchayati Raj members,

women must also be involved in this process, not only as beneficiaries but also as decision-makers. The Community Needs Assessment Approach needs to be institutionalised as an instrument of decentralised planning, implementation and monitoring of health and family welfare plans. Separate resources must be allocated for this process.

12. The commitment to converge service delivery (health and family welfare) must be followed with clear strategies, plans and indicators. This is essential both for efficiency and for increasing access, especially for women who are furthest from the services.
13. New health and family welfare monitoring indicators must be developed which will enable gender differentials to be understood and addressed. These monitoring indicators should be so designed that they may be used for monitoring the plans at the community level as well.
14. It is not enough to have women's cells and Women's Component Plans in different Ministries/Departments. WCPs need to be developed and monitored with the assistance of Gender Advisory Bodies that will engage in gender planning and audit of the relevant Ministries/Departments. Such bodies must include in their membership persons from women's groups.

Notes

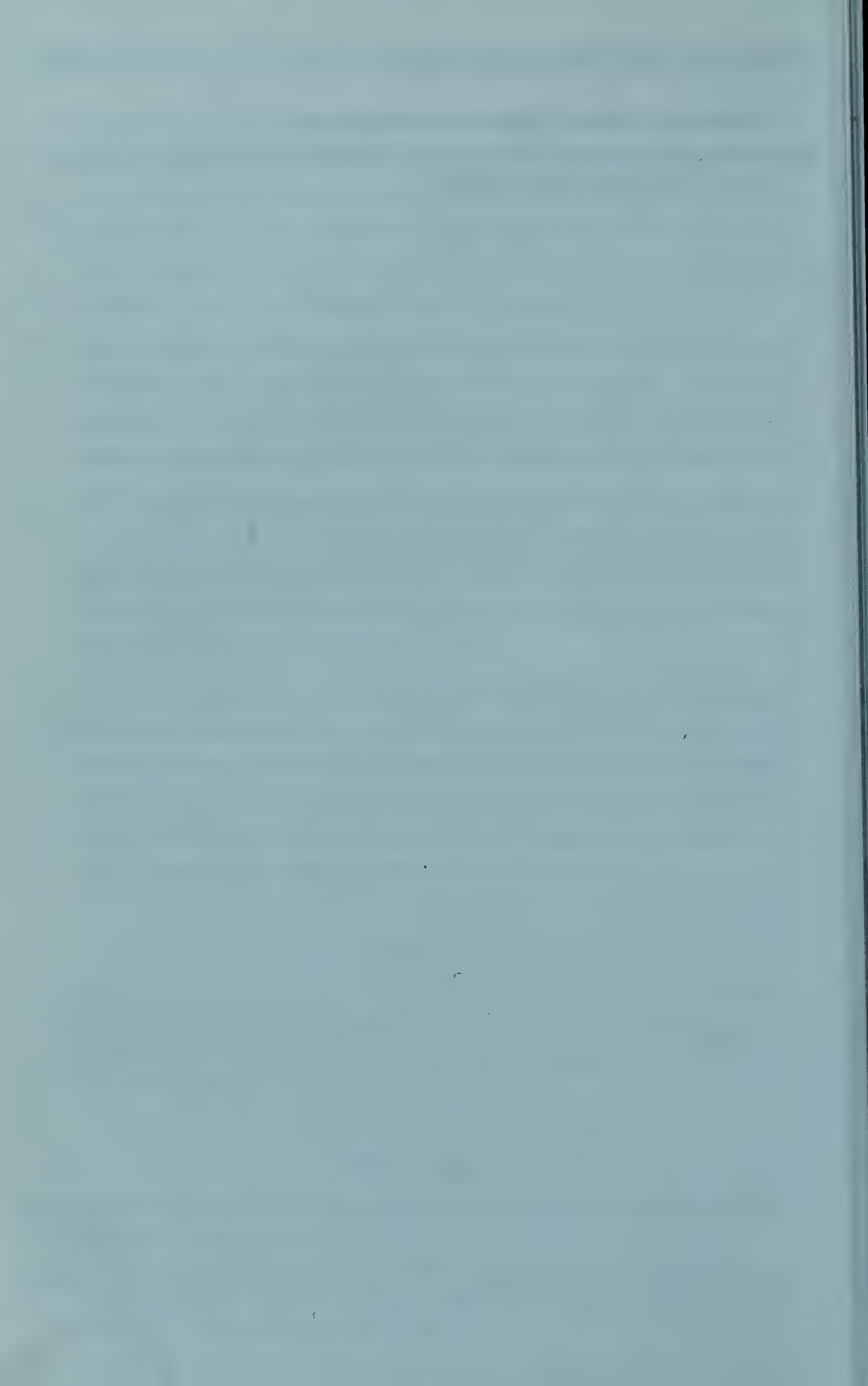
1. This paper was prepared as a background note on behalf of SUTRA, Himachal Pradesh for 'Engendering the Tenth Plan - Regional Consultation on Population, Gender, Health and Reproductive Rights' November 29- 30, 2001, Chandigarh.

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Part 5

National Health
Policy and
Programmes
from Women's
Perspective



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Chapter 17

Women's Health Policies and Programmes

A Critical Review

Imrana Qadeer

Though India has never had a clear-cut policy for women's health, a range of policy decisions has directly or indirectly influenced women's health. The closest that India ever came to a health policy for women was in the report of the National Commission on Women in the Unorganised Sector, though this only addressed their occupational health. The second document that touched on women's health was the Government of India's statement on population policies as reported in the annual report of the Ministry of Health and Family Welfare. The focus here was on the Family Planning Programme but since this has now acquired a Reproductive and Child Health slant, women's reproductive health is now an official concern. However, women's health covers much more than their occupational and reproductive health. A comprehensive policy on women's health as a strong component of the overall National Health Policy is thus urgently needed.

Policies that Affect Women's Health

Despite the absence of an explicit health policy, the Five Year Plans, as well as a number of special committees, have implicitly provided policy measures for women's health. In addition, the World Health Organisation (WHO) and the other international agencies also influenced policy-making in India.

Contribution of International Agencies

World Health Organisation (WHO): In historical terms, it was the issue of maternal health that focused attention on women's health. Till the 1960s, WHO's broad definition of maternity health¹ also stressed on the improvement of environmental sanitation and control of major diseases, such as malaria, through basic public health programmes (WHO 1969). Infectious processes were rightly understood to harm the foetus and the mother, if exposed. This broad-based perception of maternity health continued during the 1970s. Nutrition and infections were regarded as critical; simultaneously, hazardous and excessive reproduction was seen as a burden on women. In 1976, though Primary Health Care (PHC) and education of mothers was added to the core of services, 'unplanned reproduction' and the need to regulate fertility acquired more significance (WHO 1976) and there was a shift in emphasis from the integrated concept of maternity health to selected intervention for high-risk cases. Later, the term maternity health was incorporated into the broader terminology of 'reproductive health' (WHO 1985), which also covered abortion, contraception, HIV, AIDS, reproductive tract infections (RTIs), and sterility services. For third world countries, this expansion came at a time when even strategies for improved maternity had not succeeded. Despite sufficient evidence of the importance of communicable and nutritional diseases on women's general and maternal health (Qadeer 1995) and despite knowing that programmes against these lacked resources and suffered from poor implementation (ICMR 1989), WHO chose to broaden the scope of its definition to reproductive health (RH).

In recent years, in view of the constraints posed by Structural Adjustment Programmes (SAP), there has been a major transformation in WHO's approach to Primary Health Care. Instead of being regarded as the central actor responsible for monitoring and moderating, the state is now treated as one of the many partners in the achievement of health. Since the role of the state has been reduced, the marginalisation of the public sector in health, where investment has declined drastically to 1.2 per cent of the GNP in the case of India, is ignored. Within the present overall structural reforms, where the brunt of the cuts on subsidies affects food security systems and employment of the poorest segments, the intersectoral emphasis on PHC is diluted.

Achieving SAP is seen as the long-term solution to the ill health of the poor. This ignores the need for recognising the fact that

- the transformation of the economy through SAP is not ensured as shown by the South Asian economic crisis;
- 40 per cent of those living below the poverty line may not be able to sustain themselves through this harsh period of transformation;
- all talk of a social security net till now has been only on paper and that food and employment security for the poor is dwindling.

This then, cannot be the direction or nature of development for the third world, particularly India, nor can it be the basis for health of the Indian poor, especially women. The other important international organisations that have more or less pushed India in a similar direction are the United Nations Fund for Population Activities (UNFPA) and the World Bank.

United Nations Fund for Population Activities (UNFPA): In its document, *India: Towards Population and Development Goals, 1996* (Srinivasan and Shariff 1997), UNFPA places a lot of emphasis on gender and RH-related indices. Though it recognises the importance of unsustainable consumption and production patterns and the unsustainable use of natural resources for environmental

degeneration, it ignores the linkages between these processes and poverty. Poverty, gender inequity and demographic changes are measured and presented but their causes and linkages are not made explicit. Placing undue emphasis on demographic analysis, the UNFPA uses declining sex ratios to focus on the need for technological interventions for mortality control among women in different age groups. It does not examine declining sex ratios along with declining mortality rates. If taken together, the two would highlight the social constraints within which the same interventions would produce differential impacts on the mortality rates of men and women. No amount of counting numbers and increasing technocentric approaches to fertility or mortality control will bridge this gap unless social and economic structural issues are addressed.

UNFPA not only underplays the importance of such analysis, it also ignores general health, which is central to a population's development. Except for RH indicators, there is no analysis of data on communicable or non-communicable diseases (except for disability). Thus, even diseases that cause the bulk of health problems, and which are amenable to technological interventions, are left out of the discussion. This is primarily due to UNFPA's assumption that the distribution of health expenditure between private and public sectors, which currently stands at 3:1, cannot be reversed.

In the area of public health, UNFPA's emphasis is on reproductive health and family planning, immunisation, disabilities, and environment pollution due to transportation. Food, nutrition and safe drinking water are there but not as key factors. This selective emphasis is obviously indicative of a new paradigm of public health where choices for practical and profitable, and 'cost effective' without disturbing structural stability, are made. Human interests are thus made subservient to the interests of international capital, which operates on the basis of monetary gains alone.

World Bank: *The World Development Report, 1993* (World Bank 1993), in its effort to cut back state investment, proposed clinical and public health 'packages' where family planning through fertility control was perceived as the second most critical input into women's

health. Concern for women's nutrition was expressed but answers were sought in micronutrient supplementation rather than in making food availability the central concern. The Report argued that, except under the extraordinary conditions of famine, the government must not interfere with food markets.

The Bank's essential package included maternity care, family planning services, paediatric care, tuberculosis (TB) and sexually transmitted diseases (STDs). The second list of priorities included treatment of chronic diseases such as diabetes, schizophrenia, manic-depressive illnesses, and cancers. These priorities, based on the Disability Adjusted Life Years (DALYs) calculations, have little to do with epidemiological priorities or principles of public health practice that demand a discrete use of curative interventions on a large scale to control and prevent the spread of diseases.

The irrational emphasis on privatisation was partly curtailed during later efforts by the Bank to intervene in India's health sector planning. For example, its publication, *Development in Practice, Improving Women's Health in India*, accepts that the public sector will continue to play a key role in providing services such as family planning, maternity care and control of communicable diseases (World Bank 1996). At the same time, it makes no move to increase the share of health sector funding beyond the existing 1.3 per cent. In addition, when actually working out the details, its entire emphasis is on family welfare and maternity. This leaves communicable diseases out of women's health concerns. The document discusses postural and nutritional problems, violence against women and weight-bearing problems more than death and morbidity from communicable diseases. Thus, while problems rooted in social realities are dragged into the health sector for 'cure', those that can actually be cured by technology, and therefore lead to prevention, are neglected. Like WHO, the World Bank also emphasises the reproductive health of women but leaves the other dimensions, such as general and occupational health, to the mercy of curative markets.

We can thus see a common thread in the shifts affecting the very definition and content of PHC. A narrow, technocentric definition

of reproductive health is being given a push that marginalises other programmatic inputs which are more critical for women's health. The following sections examine the process of health planning in India and the international influences on it.

Contribution of Women's Groups

Much of the credit for the current focus on the plight of women and their poor health must primarily be given to the women's groups in India. Their active and constructive participation in the International Conference on Population Development (ICPD) held in Cairo, and in Beijing, is clear evidence of their effective and important role in policy-making. Their efforts have helped in drawing public attention to many women's issues and given rise to public debates, which in turn have influenced policy decisions. The Medical Termination of Pregnancy Act (1971) itself was the outcome of public debate on abortion. Their active engagement with the problem of child abuse, particularly abuse of the girl child, made it a critical issue in public debate. The debate on legal procedures in rape cases and their traumatic impact on the victims forced legislators to re-look at the procedures involved.

It is also due to their efforts that public debate and action against the use of dangerous contraceptives has had success; a public interest litigation to stop the use of Quinacrine as contraceptive pellets was filed and won. Hysterectomies performed on mentally retarded girls also became a hotly debated issue wherein it was argued that state institutions can and must provide the necessary basic services and protect the young women rather than hide its callousness by performing hysterectomies. This debate got linked to the debates on trafficking of women and their sexual exploitation in the absence of social and economic security, and the issue of recognising prostitutes as 'sex workers'. The poor sex ratio revealed by the 1991 census triggered a debate on the socio-demographic implications of the dwindling size of female population and the use of medical technology for prenatal sex determination. With the imbalance in sex ratio brought out by the 2001 census, the issue is once again on

the agenda.

However, women's groups need to be adequately equipped with methodologies of policy-making and familiarise themselves with the various dimensions and determinants of health and the process and tools of planning. In the absence of this, there is a danger that these groups might be used to push inadequate strategies and methodologies.

Indian Health Planning

In 1943, the National Health and Development Committee (Bhore Committee) appointed by the Government of India to survey the health situation in the country, made two recommendations:² first that the provision of health services was the responsibility of the state; and second, that comprehensive health care was the right of all, irrespective of ability to pay. The Factories Act, 1934, which provided for maternity care for factory labour, was seen as a way to strengthen women's health. It was also proposed to provide crèches for children less than six years of age wherever there were 50 or more women workers (Government of India 1996). In 1943, the National Planning Committee of the Indian National Congress set up the Sokhe Committee, a sub-committee on health. This committee realised the importance of a centralised authority to provide services for mothers and children, the need for a national-level minimum infrastructure and the need for training paramedical workers and traditional *dais* to provide natal, antenatal and post-natal services. These, in fact, became the basis for a Maternity and Child Health (MCH) focus within India's general health services.

Five Year Plans and Special Committees

Allocations during the First and the Second Plan periods were respectively only 3.33 percent and 3.01 per cent of the total outlays, much less than the irreducible minimum of 10 per cent as recommended by the Bhore Committee. Fifty-five to 60 per cent of these resources were, in turn, allocated to curative health services

and medical education, which became a trend for the future (Government of India 1951, 1956). Though 'maternal health' was initially given prominence, it soon became secondary to family planning, which was perceived as an urgent national need. Even within MCH, more weightage was given to child health rather than that of the mother as Infant Mortality Ratio (IMR) was linked to fertility but maternal mortality was not. In the beginning, investment in 'family welfare' was lower than in health per se, but the gap between the two has reduced over time.

In the Third Plan, health allocation decreased to 2.63 per cent of the total allocation (Government of India 1965), with the Family Planning Programme (FPP) receiving a great deal of emphasis. This was due to the higher rate of population growth shown by 1961 census. The official acceptance of this policy came through the Mukherjee Committee Report (Government of India 1966), which also recommended specific targets and incentives.

The UN Advisory Mission (1966) also recommended the de-linking of MCH from family planning services. In 1967, however, because of the close linkage between MCH and family planning, it was decided to integrate MCH with the FPP 'with a view to giving a broader base to the Family Planning Programme' (Government of India 1968). Shifted from general health services and used as a prop for the FPP, maternity services soon became lopsided.

In the Third Plan period the Mudaliar Committee recommended that expansion of services be stopped and the existing Primary Health Care centres or PHCs (less than 2000) be consolidated. It proposed mobile dispensaries for far-flung areas where no PHCs existed and assumed that the growing urban services and communication and transformation network would help rural population avail urban medical care services.

Though never fully accepted, its recommendations set in motion a shift in favour of urban areas at the cost of rural areas. Thus, during the Third Plan period, the attempt to integrate the services for family planning, control of communicable diseases and MCH at the PHC

level, did not succeed fully and, in the process, MCH was ignored due to overemphasis on and the target-oriented approach of family planning work.

In the Fourth Plan period, the budget allocation for health further decreased while that for FPP increased phenomenally. Health obtained Rs. 433.5 crores whereas FP got Rs. 315 crores (respectively 2.12 per cent and 1.76 per cent of the total outlay). During this period, the major thrust was on vasectomy through the 'Camp Approach' (Government of India 1969), which received financial support from a host of international aid agencies. By the end of this Plan period, MCH had been successfully overshadowed by FPP. Then, in 1973, the Kartar Singh Committee (Government of India 1973) recommended the integration of grassroots-level workers, designating them as multipurpose workers. In this scheme, maternal health work became one of the many activities of the female multipurpose workers (Government of India 1973).

Another scheme that was proposed to strengthen MCH services was the Integrated Child Development Scheme (ICDS), where mothers were also targeted for nutrition and education (Government of India 1975a). The scheme ran into many problems due to double control by different ministries, namely the Health and Family Welfare and Human Resource Development ministries (ICDS is under the latter's Women and Child Development department).

As a consequence, the Fifth Plan made an effort to integrate FPP, MCH and Nutrition Services through ICDS (Government of India 1974). The Plan noted that 'the primary objective is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups.' This shift was a manifestation of the changing perspective on development. The Minimum Needs Programme was therefore launched, taking into account the needs of the poorest. In addition, the population policy pronounced in 1976 talked about female education and raised the age of marriage to reduce birth rates (Government of India 1976).

However, the entire situation changed after the promulgation of the

Emergency, which called for a direct attack on the population problem. During this period, even before the new perspective could manifest as concrete programmes, the Ministry of Health and Family Planning opted for compulsory sterilisation – a strategy that led to major political turmoil (Government of India 1978).

With the change in government in 1977, the FPP was announced as a voluntary programme, an integral part of a 'comprehensive policy' covering education, health, MCH and nutrition. The Srivastava Committee (Government of India 1975a) had already recommended the strengthening of rural health care services. The government thus introduced the Community Health Volunteer (CHV) scheme in the year 1977. With the slogan, 'Peoples' Health in People's Hands', the CHV joined the PHC network to make health services more meaningful. Alma Ata's people-oriented strategies of 'Health for All by 2000 A.D.' were accepted by India in 1978, when FP and MCH became a part of basic health services (Government of India 1981a). Enthused by the Alma Ata declaration, a draft policy in 1979 not only accepted primary health care as central but also proposed 'bold attempts to ensure 100 per cent health coverage in the next 10-15 years for children'. Though it expressed concern for high maternal mortality, the main focus remained child survival (Government of India 1979).

The Sixth Plan emphasised infrastructure development and integration of services at the PHC level. This plan bravely attempted to curtail the unbridled rise of resource investment in family planning and increased inputs in programmes for disease control. It proposed to bring down infant and maternal mortality through extension programmes such as the Extended Programme for Immunisation, Anaemia Prophylaxis, Supplementary Feeding and ICDS. Despite this emphasis, it was during this period that the CHV scheme was abandoned and medical care was opened to the non-governmental sector, including the private sector (Government of India 1981b).

There are three important documents that need special mention here, two of which were published in 1980. One was the *Report of the Working Group on Population* (Government of India 1980) and the

other was a *Report on Health* by a joint Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR) committee (ICSSR and ICMR 1981). Both talked of intersectoral development as a prime need for health and population planning. They emphasised the need for integrated health care services and maternity and child care services for generating demands for family planning services. The latter report was particularly emphatic about proper policies for welfare, especially in the area of nutrition, and taking people's perceptions, cultures and history into account when planning their participation. In contrast, the National Health Policy of 1983, despite its concern for fulfilling unmet needs, reiterated the need for opening medical care to non-governmental and private sector investment (Government of India 1983).

The Seventh Plan more or less continued with the same trends except that during the plan period, the will to restrain vertical FPP and invest in a more integrated welfare strategy was lost and resource investment in FP again started increasing. No specific measures were proposed for the general health of women except raising their consciousness about health issues through education and communication programmes. Instead, organising women around economic activities was proposed to enable their participation in socio-economic development. During the same period, AIDS emerged as a new public health problem and the National AIDS Control Programme was launched in 1986 with loans from the United States and the World Bank (Government of India 1985, 1993). New vertical disease control programmes, such as those for blindness and non-communicable diseases, were added and a technocentric approach to ischaemic heart diseases, rheumatic heart diseases, cancer and mental health was proposed.

The Eighth Plan was conceived during a very critical period, when India formally accepted Structural Adjustment Policies prescribed by the International Monetary Fund (IMF) and the World Bank (Government of India 1992). Its main features vis-à-vis health were: sharp cuts in investments for welfare, especially in the health sector; privatisation of medical care; opening up of public sector in health

to private investments; and massive cuts on public distribution systems. Instead of ensuring basic minimum facilities to all, the Plan focused on health for the underprivileged. The shrinking focus was accompanied by a strategy to consolidate rather than expand the PHC network, which meant strengthening physical and technical aspects such as supply of equipment and drugs, education and provision of training to personnel. Poorer states that had inadequate health infrastructure suffered; they received comparatively lower investments for consolidation, as the Plan could not provide for the infrastructural backlog of these states.

The vertical approach to disease control continued, with the FPP acquiring yet another hike in resource allocation. It was during the Eighth Plan that emphasis on female literacy, employment, improved social health and nutritional status, and increase in the age of marriage was recognised as important. Yet, social development was left to a 'pool of fragmented schemes', while health policy focused on provision of contraceptives, sterilisation, safe motherhood and child health services (Government of India 1992).

The Eighth Plan period saw three other policy documents. The Country Statement from India at the ICPD made all the correct political statements and then reverted to calling family planning a 'basic need'. The Draft Population Policy made even more radical proposals such as a non-target approach, better inheritance laws for women, integration of health and family planning and MCH services, and gender-sensitive, sustainable and equitable development. At the same time it retained the primacy of population control for which it suggested legislative steps, including cutting off of employment and promotional and electoral avenues for those who had more than two children. The Country Statement for Beijing elucidated the Government of India's commitment to the Reproductive Health approach (Government of India 1994).

The Ninth Plan signalled a paradigm shift by declaring 'Empowerment of Women' to be one of its nine primary objectives. It adopted a special strategy of 'Women's Component Plan' to ensure that not less than 30 per cent of funds/benefits flow to women from

other developmental sectors. Two important policy documents have come up during this plan period – the National Population Policy (NPP) 2000 and the Draft National Health Policy (NHP) 2001. Though the NPP 2000 focuses on improving the quality of people's lives, it is still very much within the demographic framework of bringing down the Total Fertility Rate (TFR) to replacement levels by 2010. Promoting delayed marriage for girls rather than promoting vocational training and occupational opportunities for empowerment, for instance, reflect its goals related to fertility reduction (Government of India 2000).

Similarly, the Draft NHP 2001 recognises that social, cultural and economic factors continue to inhibit women from gaining adequate access to even existing public health facilities. This not only affects women as individuals but also has an adverse effect on the entire family, particularly children. Though the Draft NHP 2001 also recognises the catalytic role of empowered women in improving the overall health standards of the community, the emphasis once again is on population stabilisation to improve health standards. The principal common features covered under the NPP 2000 and the Draft NHP 2001 relate to the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunisation of children against all major preventable diseases; and addressing the unmet needs for reproductive and basic health services. The Draft NHP 2001 calls for a synchronised implementation of these two policies to improve health standards in the country. However, its undue emphasis on privatisation of medical care, the selective approach to disease control (irrespective of actual community needs assessment) and Primary Level Care (instead of Primary Health Care), actually distort its professed priorities (Government of India 2001).

The Approach Paper to the Tenth Plan states growth with equity and sustainability as its objective. Health and nutrition are part of the 'social infrastructure'. This social infrastructure, as reflected by the latest draft policy document on health, does more for the free market rather than for the health of the underprivileged.

Legislation and Women's Health

Legislative measures that influence women's health have evolved as a part of the struggle for welfare. With the Medical Termination of Pregnancy Act (MTP) of 1971, India adopted a progressive and liberal abortion policy. The MTP Act was a bold step and its implementation too has been active. However, the number of illegal abortions is much higher than legal abortions. The fact that between 6 and 9 per cent of the abortions are among adolescent girls and 16 per cent among women aged between 20 and 34 shows the need for adolescent health care and that abortion is used as a family planning technique. A negative development has been its linkage with sex selective foetal destruction, and the growth of clinics that make use of abortion services for foeticide. The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Bill, 1991, aimed at curbing sex-selective abortion, became inadequate even before it was passed due to the use of ultrasound; however, nothing has been done about it (Voluntary Health Association of India 1991).

The Maternity Benefits Act, 1961, provides for 12 weeks' maternity leave for women alone and only to those who have put in 160 days of work within 12 months of the expected date of delivery. As most women in the unorganised sector never manage to retain continuous employment, this does not benefit them.

Despite the existing Drug and Cosmetics Act, a number of harmful drugs are sold openly in the market without display of any warning. This often proves dangerous for pregnant women and children.

Among the occupation-related legislations that also cover women, the Factories Act provides for separate toilets for women, resting places for them, and exemption from working at night and from hazardous work — cleaning, oiling or repairing moving machines and lifting heavy weights. The Mines Act prohibits employment of women for underground work. These provisions, however, have acted more as a deterrent for women's employment than as protective measures for the safety of women industrial workers.

Apart from inadequate legislation, there are critical areas that actually

need legislative intervention. For example, the 1992 Draft Population Policy proposed legislative measures to give land rights to women but the 1996 ministry document on population policy ignored it. It also finds no mention in the National Population Policy 2000. A large number of women are being pushed into the unorganised sector that is beyond the pale of legislative control such as Minimum Wages, Employees State Insurance and Workman's Compensation. Absence of legislative control over human population research turns women into guinea pigs, as in the case of the Quinacrine trials (Rao 1997).

Programmes for Women's Health

In the process of planning, a set of programmes evolved that were critical for women's health. Over the years, the MCH, nutrition and immunisation programmes were brought into the frame of the Family Welfare Programme (FWP) and have been finally transformed into a Reproductive and Child Health (RCH) strategy. Though the RCH, along with ICDS, provides a range of services to women, what is not recognised by official policy is the impact of effective general health services for women.

Integrated Child Development Scheme (ICDS)

Started in 1975, the ICDS programme provides not only antenatal, nutritional and maternity assistance, but also education inputs. Evaluation of the programme's performance through an extensive survey in 1996 (Central Technical Committee 1996) showed better results in ICDS blocks in terms of coverage in all areas of activity among women. In terms of impact, however, assessment of maternal mortality or morbidity was lacking (Punhani and Mahajan 1989), though evaluations showed improved nutritional and immunisation status. Women's services in ICDS do not cover women's general health needs. The latter, though never debated, are critical for women's health.

Reproductive and Child Health (RCH)

The RCH, which in 1996 became the official policy of the

Government of India, called for a 'target-free' approach, emphasis on 'safe motherhood', and 'empowerment' of women, along with inputs to improve child health. RCH was thus concerned with empowerment of women, their good health and self-respect based on social recognition. This called for a multipronged strategy to improve women's economic and social status and create opportunities for education, employment and security for their families. However, RCH did not extend beyond the Department of Family Planning.

RCH medicalises deliveries as it attempts to push hospital deliveries irrespective of 'risks' involved. This is contrary to the principle of reducing unnecessary burden on institutions by providing good home delivery facilities through trained personnel, good referral services for institutional care, and capacity building for supervised home deliveries by trained personnel including traditional *dais*. The practice of hospitalisation for normal deliveries in cases other than primi is uncalled for. It invalidates past efforts at improving the practices of traditional practitioners and undermines the value of their empirical knowledge. Also, by increasing the workload of institutions, it undermines their ability to provide good care to high-risk cases or complicated deliveries.

General Health Services

Among the national health programmes only the National Malaria Control Programme was integrated; others like leprosy elimination, Kala Azar control, filaria control, and blindness control remained vertical. The National Tuberculosis Programme was actually modified into a more or less vertical programme. Based on the experience of developed countries, Directly Observed Treatment (DOTS) with multidrug regimes became a part of the strategy. These regimes lack epidemiological basis, as neither is bacterial resistance epidemiologically significant in India nor is the national health infrastructure fully equipped to provide and monitor DOTS. In fact, the standard regimes continue to be relevant and necessary for Indian conditions (Banerji 1997).

The vertical programme for leprosy has, at best, reduced severity of

morbidity but elimination remains a distant goal (Tare 1990). Most of these programmes need a thorough epidemiological review and restructuring, with a view to integrate them into the general health services. Without this exercise, increasing investment will add to wastage of resources. For improving the health of the women, this remains a basic requirement.

Main Trends in Policies and Programmes

The present programmes for women's health are thus based on ICDS and restricted RCH strategies and rooted in the linear and purely technological approach which focuses on women as targets; NGOs as providers; privatised medical care; and on a reproductive health of women that has no epidemiological rationale.

Focus on Women

The Family Planning Programme has always focused only on women. After a brief experiment with popularising vasectomies in the 1970s, the programme once again revived its focus on women, excluded their ill health, and dealt with their reproductive capacity. The logic behind this approach is stated to be the greater extent of suffering borne by women as a consequence of frequent pregnancies and births. It is also argued that the ill effects of currently introduced hormonal contraceptives are likely to be much less than the negative impact of numerous pregnancies.

Though hormonal contraceptives are being pushed in the name of women's right to have more choices, it is clear that they have no role in the making of these choices. The funding agencies are calling the shots and setting directions for research. Thus, while traditional and barrier methods – that contributed to the demographic transition in the West – have been neglected, hormonal contraceptives have been patronised.

Women are thus denied the chance of using a really safe and user-controlled contraceptive because research funds are diverted to find surer, though not safer, contraceptives that are provider-controlled

and that make women dependent. This technocentricity of a woman-centred population policy is in fact damaging the health of women rather than improving it.

Focus on Non-Government Organisations

The latest strategy of funding voluntary agencies to open clinics and operation theatres to provide sterilisation, IUD and spacing services, is yet another attempt to avoid confronting the challenge of enhancing informed choices and providing safe contraceptives and integrated services, especially for rural areas and slums. By shifting responsibility, this strategy raises a host of questions. Can the inadequacy of primary health centres be overcome by opening sterilisation wards? What is the logic of investing in independent institutions at the cost of the PHC network? The official documents are silent on these questions.

NGOs have a dichotomous relationship with official institutions. They need funds and at the same time need to keep their structures independent to retain their creativity and autonomy. Being close to communities, they can act as providers of information and organisational support. But the bureaucracy wishes to use them as cheap providers of their programmes and wants them to remain under official control and monitoring. The conflict, therefore, changes with the nature of the NGO, as there is no uniformity within the NGO sector. Most NGOs work in specialised areas and are in no position to offer comprehensive services. Secondly, given the inability of the state to exercise any control over them, there is no way to ensure standardised quality.

Privatisation of Medical Care

There has been an increasing pressure over the years to give up the commitment that independent India made – provision of health care irrespective of one's capacity to pay.

Two basic arguments have been put forward to support this:

- There is a significant proportion of the population that can pay for services and does not need subsidised care. If they go to the

private sector, then the public sector will be able to provide adequately for the poor.

- Tertiary level care, which is the most expensive and most used by the well off, draws resources from primary health care and undermines it. Hence we need to invest only in Primary Health Care and cut down on tertiary level care.

It is also argued that since resources in the public sector are scarce, it must be opened up to private investment. These assumptions are very simplistic and have implications for the national disease control programme. Most communicable disease control programmes are based on secondary prevention. Privatisation of medical care will therefore completely dislocate all efforts at standardisation of treatment, epidemiological monitoring and adequate coverage in poor countries where 40 to 50 per cent of the population live below the poverty line and cannot seek medical care (Qadeer 1994). In India, the problems created by private sector treatment strategies, such as irrational use of drugs, in tuberculosis and malaria are well known (Phadke 1995).

The private sector, which works for profit, cannot be expected to provide for epidemiologically significant priorities that do not necessarily manifest as expressed wants. Treatment of anaemia, good antenatal care, basic immunisation services, provision of information to women and preventive activities for disease control must continue to be a function of the public sector.

Within RCH, there is a need to pay heed to what women are saying and asking for. Failure to do this has affected the programme negatively. Studies demonstrate that the nature of antenatal and natal care needs to be altered and based on women's expressed needs and conditions rather than on the medicalised view of the professionals (Sagar 1997). This calls for strengthening the cadre of female health-workers who are closest to women and can act as mediators between them and the health service system. This is possible only within a well thought-out public sector and not a private sector of health care.

The undermining of tertiary level health care in the public sector is

yet another blow to the very concept of primary health care. It converts it into an issue of 'levels' of care where primary means the lowest level. This has nothing to do with the original concept evolved at Alma Ata where a set of basic services were to be supported by two special measures — one, developmental inputs such as food, employment, sanitation, housing, roads and other welfare services; and the other, adequate support from tertiary and secondary health care services. Without these measure, primary health care cannot be considered complete. Thus, cutting back on tertiary care indiscreetly only serves to undermine primary health.

Reproductive Health – the Epidemiological Basis

Reproductive health is defined as a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. This leaves out all other aspects of health and well being. Only a full grasp of all dimensions of health can lead to adequate prioritisation of problems and a desirable policy. The Model Registration Scheme offers valuable insights in the examination of epidemiological priorities, despite its limitations. An analysis of deaths from 1982 to 1993 shows that deaths due to childbirth constitute 1.2 to 2.9 per cent of the total female deaths. MCH then tackles only these deaths and leaves out 98 per cent of female deaths! The main causes of death among women remain respiratory diseases, causes peculiar to infancy, diseases of the circulatory system (which includes anaemia), fevers and digestive disorders.

Time trends show very little decline in these proportions. The proportion of death due to injuries actually increases slightly and that due to fevers declines over the entire period. For causes falling within the purview of MCH (childbirth and pregnancy, causes peculiar to infancy and diseases of the circulatory system including anaemia), there is an initial decline in proportions till 1988-89. Then a slight but consistent reversal of this trend sets in.

To acquire a better idea of the distribution of causes, we have identified from each group specific communicable diseases. Deaths due to gastroenteritis, cholera, dysentery, tuberculosis, pneumonia, whooping cough, meningitis, jaundice, tetanus, chicken pox, measles and poliomyelitis have been clubbed together to look at three specific groups of causes – communicable diseases, maternal deaths (deaths related to pregnancy and childbirth) and anaemia. The age-specific death load for the three groups shows that, in all age groups, communicable diseases cause the highest proportion of deaths. In the 15-44 years age group, maternity deaths range from 11 to 18 per cent but there is no definite pattern. A visible trend is the virtual stagnation of the pattern of distribution of deaths within this age group. The slight decline in the proportion of deaths due to communicable diseases in the 15-44 years age group is compensated by a slight increase in the proportions of maternal deaths. The non-communicable disease and anaemia deaths show little change except during 1992 and 1993, which needs cautious interpretation.

When we look at deaths due to anaemia in the 15-44 years age group, we find that as a complication of pregnancy it has certainly not declined, as its share came down from 3.4 to 1.93 per cent in 1988 and then again rose to 3.07 per cent in 1993. General anaemia (without pregnancy) is an equally serious threat to women's lives. Even if the 1993 figures are treated with caution, the rising contribution of general anaemia to deaths cannot be denied.

If we add to this the low levels of average calorie intake, as shown by the National Monitoring Bureau data, the picture of general health becomes very poor. For example, in nine major states, for 1975-78, women who were sedentary workers (requiring 1900 calories) showed a mean calorie intake of 1307-1816 in all states except one. For moderate female workers also, all except one of the nine states had values less than the required 2200 calories and here, too, the range of mean intake was between 1141 and 1976 (National Nutrition Monitoring Bureau 1980). This reflects the severe deprivation of adult women in Kerala, Tamil Nadu, Andhra Pradesh, Maharashtra, Gujarat, Madhya Pradesh, West Bengal and Uttar Pradesh. In 1996,

among the sedentary workers, the mean calorie intake went above the recommended levels in two out of eight states, and for moderate women workers four states had values above the required calories. In the 1996 data, however, Uttar Pradesh and West Bengal were replaced by Karnataka and Orissa (National Nutrition Monitoring Bureau 1996).

Links between Maternal Mortality and Diseases

Women's poor nutritional status, high prevalence of anaemia, and communicable diseases complicate reproductive health. Unfortunately, very little national-level data exists to demonstrate this association. If we examine the cumulative data for the years 1966, 1967 and 1968³ on deaths due to toxemia, hemorrhages, complication of pregnancy, sepsis, abortion and post-natal complications and, along with these, maternal (obstetric) deaths with associated medical conditions such as tuberculosis, anaemia, dysentery and smallpox, we find that among the total registered maternal deaths, up to 16.39 per cent mortality is caused by complications due to associated causes. Given that all deaths were not certified by medical personnel, and complications such as cerebro-vascular diseases, diabetes, etc., were not considered, the detection of associated causes could only be an underestimate. In other words, the underestimation of the underlying ill health associated with obstetric deaths is not an insignificant issue. Even though such data for the present is not available, given the almost static levels of mortality and the return of epidemics of malaria, Kala Azar, hepatitis, plague and dengue, it is doubtful that the 2000s will present a more hopeful scenario.

The Model Registration data thus emphasises the following:

1. The importance of dealing with the health problems of girls under 15 years of age, who bear a high load of mortality and who enter their reproductive period with a disadvantage.
2. The importance of communicable diseases, which not only kill the young but remain the second major killers of women in the 15-45 years age group.

3. The inappropriateness of exclusive RH interventions for women in the reproductive age group when communicable diseases, anaemia and malnutrition are the major killers across all age groups.
4. The need to retain focus on maternal mortality rather than opting for broadening the base of Maternal and Child Health services in the face of severe cuts in health sector investment. This broadening into peripheral areas of RH will dilute the efforts of the public sector, which, because of FPP, is already concentrating investment in contraceptive services.
5. The need to recognise the impact of general illness on maternal health as the complications caused add to maternal mortality.

This data gives a clear basis for policy-level interventions in the area of public health. It also partly explains the 'silence' of poor Indian women on the issue of reproductive health and rights other than basic maternity services.

RCH needs to be fully integrated into disease control and nutritional programmes. It also needs to expand its focus from infant and maternal mortality to lowering child death rates and deaths due to communicable diseases among women and young girls.

Conclusion and Recommendations

This review of policies and programmes delineates the main constraints of the planning process that have serious implications for women's health. Changes in health and population numbers are seen as two independent processes without recognising the links between population, general health and development. In other words, conceptual integration along with a fully integrated structure that is responsive to a variety of health needs is a necessary prerequisite for improving the health service system.

Though the socio-economic correlates of health were acknowledged by the Bhore Committee in 1943, it was only in 1978 that they were incorporated into PHC planning in the form of intersectoral development to provide comprehensive facilities for livelihood.

Available evidence reveals that technocentric services by themselves are not sufficient to achieve good health. For the health of women, this neglect becomes even more critical, given their secondary position in the family and their caring responsibilities. Without ensuring women their share in employment, adequate availability of food through strengthening food security systems, education and supportive legislation, health policies and programmes will continue to lack comprehensiveness.

The single most critical programme for women's health has been the FPP. It not only appropriated MCH but also reproductive health. It did not permit a genuine realisation of the approach that tackles all aspects of women's health, including their occupational, general and nutritional health. Maternity and reproductive health have become vehicles for FPP rather than its objectives. The obsession with fertility control makes women the target for population control rather than subjects involved in their development and empowerment, including control over their own fertility. The massive investment in FPP has led to distortion of resource allocation at the cost of women's health. This is reflected in poor inputs into MCH programmes and communicable disease control. There is pressure on India to incorporate non-communicable diseases in its public sector health programmes. However, currently the health sector only offers curative services and can therefore play a limited role in prevention. The strengthening of secondary and tertiary level support systems within the public sector is crucial as primary health care is not a notion about levels. It calls for secondary- and tertiary-level support for peripheral units within a district health service where referral systems are well established. The present policies do not provide any strategies for monitoring and control of the private sector, which is now dominating medical care. Legislations that influence women's health, employment and rights are weak and cumbersome and primary health care is not yet a basic right.

There have been targets for Family Planning and later for MCH (such as the number of beneficiaries, the number of deliveries, number of women receiving antenatal and post-natal care and the number of

women and children being immunised), but none for women's health. Even the efforts to fix targets for coverage of population in the Revised National Tuberculosis Control Programme and the National Leprosy Eradication Programme pay no attention on women per se, even though it is well known that their access to services is poor.

The effort to ensure safe motherhood and reproductive health through the RCH approach is a step forward from what FPP was earlier. Its target-free approach, its effort to involve users and providers by focusing on improved quality of MCH and self-assessment of goals by ANMs certainly gives FPP a new turn. However, from the point of view of women's health, this still remains a limited view of her problem, as it leaves out the major cause of women's mortality and morbidity – communicable diseases. RCH therefore must take this final leap of integrating FPP, RCH, Nutrition and Communicable Diseases Control Programmes.

Health is not a simple issue of distributing pills (be they nutrient, curative or contraceptive). It calls for ensuring full employment and women's right to protect themselves, their jobs, their land, and their children. It requires that women have access to public distribution systems and welfare services that extensively cover the deserving and cater to their needs. Central to health are the following factors:

- Provision of potable water, which is gradually becoming a scarce resource, threatened or polluted by the uncontrolled growth of hazardous industries.
- Better living and working conditions for women who are increasingly being pushed to take up jobs in the unorganised sectors of industries at low wages and high risks to their health.
- Social justice for women through revamping legal and institutional support structures.
- Education for the sake of learning and not only as a means to bring down fertility and control births.
- Provision of Comprehensive Primary Health Care, with a special focus on making health services accessible to those women who

are the first to get marginalised in conditions of scarcity and financial constraints, and not the Selective PHC which emphasises population control strategies.

Adequate intersectoral inputs, such as agriculture, housing, transport and drinking water are required to make the Comprehensive Primary Health Services effective.

Within this broad policy framework it is recommended that women's health can be promoted only if:

1. The separate departments of Health and Family Welfare are fully integrated into a single department.
2. Under the Commission for Women, a sub-committee is created to constantly review and monitor intersectoral planning for health.
3. A policy statement on Health and Family Welfare is worked out on the basis of the links between the two.
4. Mechanisms are developed to monitor and guide standardisation of treatment, information pooling and quality of care, both in private and public sectors.
5. Legislative measures are taken regarding access to information, right to provision of PHC, and improvement in existing legislation.
6. The vertical nature of health programmes is replaced by ongoing integration evolved on the basis of a health systems approach with epidemiology-guided goal monitoring.
7. Increase in the share of health sector inputs to strengthen the public sector, which alone can reach out to the underprivileged.
8. Emphasis on training and improving the work conditions of paramedical staff.
9. Provision of basic drugs, equipment, and laboratory facilities to primary and secondary units. Judicious investment in tertiary units.

10. Recognising the strengths of traditional systems, particularly the empirical knowledge of traditional *dais*. Creating spaces and mechanisms for mutual enrichment.

Notes

- 1 WHO defined maternity health as: 'In the narrow sense it is the care of the pregnant woman, her safe delivery, her post-natal examination, the care of her newly born infant and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well being of young people who are potential parents, and to help them develop the right approach to family life and to the place of family in the community. It should also include guidance in parent craft and problems associated with infertility and family planning' (WHO 1952).
- 2 The Bhore Committee was apparently influenced by the Beveridge Committee in England, which had given birth to the National Health Service in the country, and by the extraordinary progress of health services in the Soviet Union.
- 3 During the 1960s, when the reporting systems were more open, the Ministry of Health and Family Planning published useful statistics on this problem. This was subsequently discontinued.

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Source: "Towards Comprehensive Women's Health Programmes and Policy, edited by Renu Khanna et al. published by WAH!!, Ahmedabad. 2002

*Chapter 18***Decentralised Planning Policy****Learning from the Field****Nirmala Murthy**

In 1995, when India decided to convert its family welfare programme into a Reproductive and Child Health (RCH) programme, total fertility rate had already come down from 6 in the 1950's to 3.4 in 1993-94. During the same period, infant mortality rate (IMR) had declined by about half, from 146 to 79; maternal mortality from 8 to 4.2 per 1000 births, while life expectancy at birth had doubled to slightly over 60. Nearly half the married couples were using contraception and over 60 per cent children were protected against vaccine preventable diseases (NFHS 1993). These health statistics indicated that though India was marching towards the goal of Health for All by the year 2000, announced in the Health Policy document of 1983, the progress was slow, falling short on important goals by 20-30 per cent.

Though the Indian family welfare programme had many strengths, such as its size and the number of services provided, its main weaknesses were inadequate population coverage and poor service quality. Various evaluation studies attributed these to lack of staff, equipment and supplies, and also to the government's policy of using

contraceptive targets and incentives to pursue the goal of fertility reduction. Contraceptive targets were particularly blamed for poor service quality because they diverted the attention of the health staff away from health services. Early in the programme, targets were adopted as a management tool to bring fertility rates down rapidly. Unfortunately, some irrational practices crept into the target-setting process, and the 'carrot and stick' approach used to implement them encouraged health-workers to use any means to achieve targets – giving women incentives, false promises, using pressure and ignoring other services.

For many reasons, the maternal health services were particularly affected by this. One reason was the gender bias prevalent in India, both in general and in the perception of illness in particular: male illness gets more attention than female illness, even though morbidity rates among women in the reproductive age group of 25-44 years are much higher than among males – almost 100 per cent higher in the rural and 50 per cent higher in the urban areas (Duraismy 1998). Poor maternal health results in about 30 per cent babies being born with low birth weight and over 50 per cent children under five being undernourished, though the National Family Health Survey (NFHS) did not find gender bias in nutrition deficiency (NFHS 1993).

Another reason was the policies of donor agencies that fund various programmes. India has been quick in responding to various international policy shifts. For example, after the Alma Ata declaration on Primary Health Care (PHC), India adopted a comprehensive PHC strategy and appointed multipurpose health-workers and community health volunteers to deliver primary health care at people's doorstep. But within a year of signing that declaration, when the Selective Primary Care approach was proposed as a cost-effective alternative to the Comprehensive PHC approach (Walsh and Warren 1979) and was quickly accepted by major donor agencies, India followed suit. With support from the United Nations Children's Fund (UNICEF), it introduced a child survival programme that provided a package of services consisting of growth monitoring, oral rehydration, breast-feeding and immunisation (GOBI), giving

primacy to the expanded programme on immunisation (EPI). To this package, the Government of India (GOI) added a few maternal care services and called it the Child Survival and Safe Motherhood (CSSM) initiative. Notwithstanding its name, the initiative mainly focused on increasing child survival, giving very little attention to safe motherhood.

In 1994, when the International Conference on Population Development (ICPD) in Cairo, Egypt, urged countries to make reproductive health services available through their PHC systems, the Indian government once again responded rather quickly. It decided to convert its family welfare programme into an RCH programme, and to be consistent with the spirit of ICPD, it also agreed to abandon the system of setting contraceptive targets.

Under the RCH programme, the Indian government committed to providing a package of reproductive services such as safe delivery, pre- and post-natal care, abortion, treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), counselling on sexuality and responsible parenthood, and contraceptive services. Some of these services are currently available, some need strengthening, and some are to be newly introduced in the programme (Pachuri 1998). It was envisaged that the service package would be delivered through local health planning, improving service quality and increasing client satisfaction. This decision was a result of many years of lobbying and sustained dialogue between different stakeholders – service providers, women's advocates and programme administrators.

Here, we focus on the current field situation in the context of RCH, how the latest policy changes are being implemented, the role played by public and private service delivery, as well as the role of women in improving the range and quality of RCH services.

Historical Context of RCH

RCH has been built on the earlier family welfare programme, which

in turn was built on the old family planning programme. Until 1971, Maternal and Child Health (MCH) and family planning were separate, vertical programmes. MCH was in the state sector while family planning (FP) was a central programme. There were MCH sub-centres and FP sub-centres, depending on where the funds came from. Auxiliary Nurse Midwives (ANMs) from both types of centres were expected to provide similar services — care for mothers, children and family planning. However, for historical reasons, MCH sub-centres provided more of mother and child care while FP sub-centres stressed on family planning. ANMs in MCH sub-centres were generally older, better trained and more respected because they delivered babies, compared to ANMs in FP centres, who were younger and provided mainly contraceptives services.

During the late 1960s, large vasectomy camps had become a very familiar sight. Preparation for these camps in terms of finding 'cases' overshadowed the regular activities of the health centres. The typical fallout of these camps was widely publicised, infected cases were not properly attended, and wrong men were sterilised for incentive money and promises that were not kept. Predictably enough, the reputation of FP workers plummeted. They could not motivate cases because they had nothing to give in return. To reclaim some measure of credibility, they wanted, like the other health-workers, to distribute medicines and vaccines; or they wanted the 'power' to certify ration cards or issue birth certificates to increase their status in the community. These demands contributed to the government's decision in the early 1970s to integrate health and family planning and create a cadre of multipurpose workers who would deliver health and family planning services in a smaller area covering a population of about 5000.

While FP workers were happy with this change, health-workers were unhappy that they had been given the unpopular task of achieving family planning targets. Then came the Emergency (1975-77), during which the MCH services were as good as suspended. In its aftermath, however, family planning became family welfare, signalling a reorientation of the programme to give equal priority to family

planning and MCH.

But until 1996, family planning continued to dominate the family welfare programme. Workers had to meet sterilisation targets, even if it meant ignoring MCH services. ANMs were conducting fewer and fewer deliveries because they were busy looking out for family planning cases. Many families avoided them for fear of having a family planning method thrust upon them. In even as recently as 1993, some studies noted that women did not allow ANMs to examine their young daughters-in-law for antenatal care, for fear of family planning (FRHS 1994).

Thus when family planning became family welfare, nothing much changed. The service package was the same, the priorities were the same, and approaches to service delivery were also the same – persuasion, incentives and pressure. Only two things changed – the programme’s name and a shift in the responsibility for contraception from men to women.

The skill to perform vasectomy disappeared from the PHCs. If a man wanted to undergo sterilisation, he was discreetly advised, ‘It is better if your wife did it, there will be less chance of a “social” problem (she becoming pregnant after the husband’s operation).’ Male doctors were afraid to touch vasectomy cases. With women they had no fear.

Women could be approached during the pre-natal period and persuaded to accept family planning after delivery. Maternal services therefore began to be seen as a strategy to promote family planning. There were written and unwritten instructions to doctors to ‘persuade’ all women delivering in government hospitals to accept some contraceptive method. Women who were not ready for sterilisation were advised to adopt Intra Uterine Devices (IUDs) or use condoms. Abortions were not to be conducted unless the women agreed to accept IUD or the Oral Pill.

As a result, the family welfare programme lost its welfare connotation and became a euphemism for family planning. The media splashed pictures of sterilisation camps where a bicycle pump was used to

pump air into women's bodies or 'speed doctors' were performing 300-500 female sterilisation in 10 hours in a single day (Banarage 1998). In monthly review meetings, district officers would reprimand ANMs saying, 'What's the use of providing Ante Natal Care services if women don't accept sterilisation?' A 'dynamic' health secretary was heard to say quite seriously, 'No point making too much of maternal care; so what if some women die, it is good for family planning.'

Such has been the history of the RCH programme in which all kinds of services and schemes have been used as gimmicks to increasing contraceptive use. It is now coming out with two new packages – essential obstetric care and emergency obstetric care (World Bank 1995). How can we be sure that these too will not be used to control fertility?

Field Situation in the Context of RCH

With an ANM for every 5000 population (per 3000 population in tribal areas), she is the most important service provider in the RCH programme. She is expected to conduct deliveries or supervise deliveries conducted by a *dai* (traditional birth attendant), provide post-natal services, immunise children, treat minor ailments, and provide family planning services.

Young and unmarried ANMs find it difficult to live alone in villages. Married ANMs have family constraints — husbands' employment, children's education and other family obligations that make living in rural areas difficult. In addition, her position in the village is determined by the caste group to which she belongs. Since most ANMs come from the lower castes, they have little credibility with clients from higher castes. Local leaders and officials are known to take unfair advantage of them, subjecting them to sexual and other harassment. As a result, ANMs do not feel safe in villages or in rural sub-centres (Mishra 1997). They prefer to commute from nearby towns, which means that they have less time at their disposal for providing services; visits to villages are uncertain and infrequent

and village women cannot depend on them for conducting deliveries, which may occur at any time.

The next pivotal functionary in RCH is the PHC doctor, preferably female. Since not many doctors are willing to join government service, their availability is severely curtailed. Those who do join, prefer and manage hospital postings. Those posted in rural PHCs complain about lack of facilities and supplies. While the ANMs in service are at least 15 per cent short of the required number; the shortfall in the required number of supervisors and medical officers is about 25-30 per cent (Department of Family Welfare 1996). A major reason for these shortfalls is that their posts have not been filled.

However, as one study reported, even if all positions had been filled, it would not necessarily assure the availability of doctors when patients need them. This is not surprising as the PHCs usually have only one doctor. In addition to attending clinics, he has to attend meetings, make court appearances for medico-legal cases, attend training programmes and undertake field supervision of; there is also his entitlement to leave and holidays. For these reasons, even with best of intentions, PHC doctors are available for only half the time they are expected to serve (Murthy and Vasan 1998).

Studies have also reported rude behaviour of health staff as a major reason for low utilisation of government health services. In a study in Gujarat, 20 per cent respondents complained that the staff at the PHC did not talk to them properly and that they had to wait for too long a time before they were attended to. Nearly 60 per cent reported going to private doctors because they believed that private doctors provided better quality services, even though government hospitals had better diagnostic equipment and better-trained doctors (Visaria and Visaria 1990).

The attitude of service providers in the family welfare programme has been shaped by years of pursuing contraceptive targets. To meet the targets, the health staff had been resorting to such practices as not informing clients about possible side-effects, not screening for

contraindication, not giving clients choice in contraception, and ignoring other health services with impunity. Over the years, people have come to look upon primary health centres only in the context of family planning. The programme also had other limitations. For instance, services like emergency obstetric care and treatment for RTIs/STDs were not available, the maternal care offered was minimum, health centres were not properly equipped, and the staff lacked technical training (World Bank 1995).

The government therefore decided to adopt a comprehensive approach to improve RCH services. This included scrapping the three-decade old practice of setting contraceptive targets and introducing in its place the Community Needs Assessment (CNA) approach; augmenting programme resources and providing staff with skill training specific to RCH services.

RCH: Implementation Experience

The government's decision to discontinue the practice of setting targets represented a paradigm shift, whereby the programme was to be reoriented from targeting demographic goals to meeting couples' health and family planning needs. The GOI issued guidelines to health-workers on how to assess a community's health needs. The steps involved included conducting household surveys; discussing local needs with local functionaries such as the *anganwadi* workers, health committee members, private doctors and Panchayat members; estimating service requirements based on birth rate estimates; and finally, arriving at a realistic estimate of 'needs'. These needs were to be treated as targets against which workers' performance was to be monitored (GOI 1996).

GOI tried to disseminate these guidelines by preparing a manual and by holding numerous state and district-level workshops. Though most states found this approach 'too complicated' and 'too time-consuming', they eliminated the word 'target' from their official reports and replaced it with 'estimated need'. Needs for maternal and child immunisation were uniformly estimated as equal to the

expected number of pregnancies based on the birth rate estimate. Methods used to estimate the need for family planning varied from state to state. In some states, workers took the average of the previous three years' performance to represent 'need'. In others, workers carried out house-to-house surveys to identify couples with an unmet need for sterilisation and spacing methods (i.e., couples who wish to stop or delay pregnancy without using contraception). Yet others instructed workers to calculate the 'need' as 10 per thousand population.

In Tamil Nadu, workers used birth-order distribution as a basis to determine need for family planning. All deliveries of parity three and above, and half of parity two deliveries were assumed to have a 'need' for sterilisation. This way, a district with higher birth rate and more high-order births would have higher contraceptive targets. Though this method did not reflect couples' felt need for contraception, it was easy to sell to the workers and was more acceptable to the officers, who were weary of using client survey data collected by the workers themselves.

Rajasthan and Maharashtra are two states that carried out needs assessment surveys. Apart from finding them too time-consuming, they ended up underestimating the 'need' for all services by about 30 per cent. On the positive side, the surveys made health-workers somewhat more client-oriented, improved their communication with clients, and enabled them to identify specific health education needs in their area. Some workers reported that the exercise of data gathering and data analysis was a stimulating one, and that they now felt responsible for meeting clients' needs.

This CNA approach helped increase health-workers' awareness of the range of services they needed to provide. Of the 15 services for which they are expected to estimate needs (Box 18.1), three relate to family planning and the rest to reproductive health services. The focus of the programme is on safe deliveries, measles, immunisation, and reducing unmet needs for family planning, in that order. Though it is too early to say when the programme's focus might revert back to family planning, some states are already giving (or arranging to

give) attractive incentives to sterilisation acceptors. Though the use of spacing methods is increasing, it is difficult to tell how much of it is because people want them and how much because they are thrust upon them.

Box 18.1

RCH Services Included in Decentralized Planning

- 1 Prenatal registration
- 2 Early registration for prenatal care (before 16 weeks)
3. Referral of high risk pregnant women
4. Treatment for severely anemic pregnant women
5. Two tetanus injections to pregnant women.
6. At least three health check-ups during pregnancy period
7. Institutional deliveries of babies
8. Home delivery attended by midwifery trained person
9. Weighing of new born babies
10. Referral of high risk new borns for medical examination
11. Full immunization to children (BCG, DPT, Polio, Measles)
12. At least 5 Vitamin A doses to children under 3
13. Treatment of child diarrhoea with ORT
14. Medical treatment for child ARI cases
15. Providing contraception to couples as per their need

Impact of CNA on RCH

The CNA approach is almost five years old and attempts to evaluate its impact on RCH service delivery have already begun. Some of the positive outcomes noted as a result of this approach are: improvement in the coverage of MCH services, increased importance of safe deliveries, increased acceptance of spacing methods among younger and low parity couples, and reduced tendency to inflate performance data. Some states have also reported improvement in

household visits by health-workers (Khan and Townsend 1998).

The CNA was earlier called TFA or the Target Free Approach. This term was causing problems, albeit in varying degrees, in all states. Immediately after TFA came into effect in April 1996, almost all states reported a decline in sterilisation operations. In the first year of the RCH programme, this decline was alarming, ranging from 10 to 50 per cent. The states with low decline attributed it to a reduction in false reporting. Those with substantial decline attributed it to the TFA. 'Without targets it is very difficult to extract work from the workers,' they reported to the government.

Not only health-workers but also doctors from district hospitals tended to cancel sterilisation camps because there were no targets. Ironically, when the targets were in force, health staff were after the clients; now that there are no targets, clients seem to be doing the chasing. Some ANMs reported taking women to private doctors because PHC doctors were not operating regularly or rejecting cases on the smallest of pretexts. Removing targets, it seemed, did not automatically guarantee that clients' health needs would be met or that their access to services would improve.

As a reaction to this decline in the number of sterilisations, some states once again imposed targets. Others sent messages that '% needs met' would be reviewed seriously; they also started reviewing institution-wise performance, not just for family planning but also for institutional deliveries and maternal deaths. Either as a result of such reviews or because everyone began to understand the real meaning of TFA, family planning performance improved during the second year, and has been continuing to improve since then.

Keeping in mind the main agenda behind the policy shift, the GOI for the first time included quality indicators like contraceptive failures and contraceptive side effects in its regular monitoring system (Box 18.2). This was to serve as a signal that these events were not to be ignored. How often these get reported and what actions follow, remains to be seen. If the government response is punitive, then it is likely that these events will not be reported; if, on the other hand,

the staff is given credit for reporting and treating such cases, it will be a major step towards improving quality.

Technical skill training is an important component of this programme

Box 18.2

Critical Indicators for Monitoring and Evaluation

Monitoring Indicators

Service Access:

1. % Deliveries conducted by midwifery trained persons
2. % Pregnant women received
3. Antenatal check-ups, Tetanus injections, Iron supplement)
3. % Children immunized against 6 vaccine preventable diseases
4. % Couples currently using contraception
5. % Households visited by health workers

Service Quality:

6. % ANC registration before 16 weeks of pregnancy
7. % Children fully immunized before they reach age one.
8. % Contraceptive acceptors report no side effects
9. % Women/men know essential reproductive health risks
10. % Women with reproductive health problems referred and treated

Client Satisfaction:

- 11 % Client reported :
 - availability of staff and medicines
 - staff being friendly and helpful
 - treatment received at health centers being effective
 - health centers being accessible and functioning
- 12 % districts developed need-based plans

Evaluation Indicators

Program Impact:

- % reduction birth rate, IMR, MMR
- % reduction in high risk pregnancies
- % reduction in low birth weight babies
- % reduction in unmet need for family planning

such that all primary health centres should be able to handle complicated deliveries, abortion, treatment of RTIs/STD, sterilisation

and IUD insertions. The aim of the programme is to make all health centres 'fully functional', i.e., to have a full complement of trained staff, required equipment, medicines and supplies, and to minimise situations wherein a health centre may have trained staff but no equipment or a vehicle but no driver. A system of facility survey through external agencies has been instituted to monitor the 'functionality' of the health centres. While the GOI has high expectations from this monitoring system, it is also aware that many of the problems uncovered may not have easy solutions. For example, a Taluk hospital functioning as a first referral unit for RCH has no anaesthetist but a trained anaesthetist is functioning as a PHC medical officer in the same district because his wife has a nursing home nearby. Such problems, though a result of irrational distribution of resources, are difficult to resolve through policy instruments.

Use of service protocols and technical assessments are also components of this programme. Our past experience with such instruments, however, has not been too encouraging because supervisors do not take them seriously (Ramana 1997). Nevertheless, some of the more developed states have decided to use them, partly to send down the message that 'quality matters' and partly to give workers an operational definition of expected quality.

Even so, the service quality may not improve for quite some time, at least not until inputs like staff, training and equipment that meet normative requirements are in place. Currently, there are significant gaps in these inputs (Verma et al. 1994). The softer dimensions of quality, such as improved privacy, convenient timings, behaviour with clients, informing clients about their entitlements and giving them choices, have not even been considered. Though these changes require very little additional resources, they call for change in attitudes of programme administrators and service providers. Most importantly, we would need to deal with the widely held belief among administrators that notions of quality apply only to urban, middle-class women and are not relevant to the rural poor. One frequently hears that rural men and women do not mind waiting at the health centres; or that they don't particularly want to choose their

contraceptive method and are happy if the choice is made for them. Doctors also argue that expecting friendly behaviour from health staff is impractical; PHC clinics are crowded, people are uneducated and do not follow instructions.

Some health staff openly say that government services are free and therefore people have no right to expect good quality services. Private doctors are friendly with patients because they have to extract large fees from them. Why would a government doctor want to be friendly? Under these conditions, improving interaction between clients and service providers becomes a Herculean task. Since these interactions take place at numerous places and under varied conditions, they cannot be supervised. The only way to improve these interactions might be to give clients powers over the service providers.

Many women see a connection between the rude behaviour of government doctors and their private practice in the evenings. In one village, many women said that they were using oral pill not for spacing but because they did not like the lady doctor and did not trust her operation skills for sterilisation. They recounted many instances of failed sterilisations performed by her in the camps because 'she wants us to come to her nursing home, there she will be nice'.

It is evident then, that rural women do have strong ideas of what is good or bad for them, who they can trust and who they cannot. However, such information is available only at the informal level and therefore difficult to capture through formal surveys. ANMs who do not become a part of women's informal network do not know what their clients really think. Government staff conveniently blame poor service quality on lack of facilities and medicines, forgetting that their own attitudes and behaviour often affect service quality — especially their lack of respect for the poor, the illiterate and socially disadvantaged groups.

Systemic Impediments

The government investment in primary health centres and sub-centres

is justified on the grounds that health services have to reach the poorest of the poor. But these centres seem to be perpetually afflicted by problems, such as shortage of medicines, lack of transport and de-motivated staff. In addition, the system is accused of being corrupt, mismanaged and wasteful of resources. When it comes to curative care, these centres are not anyone's first choice, not even of the poor. Private doctors, both in urban and rural areas, treat over 80 per cent of illnesses. The poor are generally not aware of the qualifications of the private doctors around them and their choice of doctor is usually based on proximity or recommendations from friends. Cost comes much lower as a criterion for selecting the doctor (Murthy and Barua 1998).

The poor returns from this investment can be attributed not only to inadequate resources but also to administrative constraints and procedural bottlenecks that hamper the smooth functioning of the services. For example, health-workers do not make outreach visits because they are not paid their travel allowance for months. Repair or maintenance of vehicles involves long, bureaucratic procedures. Work distribution among the staff is lopsided – the female workers are overworked and the male workers are under-utilised. There are no incentives for good work and no action against poor performance (OHFWP 1996). The system is accountable not to the clients but to the political bosses who control transfers and other benefits.

Therefore, despite government investment in primary health care, poor patients are paying high fees to untrained practitioners who fail to cure them. It can be argued that the well being of the poor could be improved if government centres made basic medicines available at reasonable charges. A small experiment in a few villages in Andhra Pradesh showed that the medicine requirement for a typical sub-centre could run up to about Rs. 1500 to Rs. 2000 per month, which is 10 times the medicine budget of government sub-centres. The government's current policy of 'free medicines' at the government health facilities is only helping the private sector to thrive.

Role of Private Sector

More and more poor and not-so-poor women are obtaining services from the private sector, both in urban and rural areas. People accept widely and uncritically the notion that service quality is better in private than in public hospitals. In one survey of rural health-workers in Maharashtra, most ANMs said that if they have any health problem, they go to private doctors. The government doctors available, they said, are not competent enough. In this survey, over 60 per cent of women with complications during pregnancy reported going to private doctors for treatment; in some cases, they were referred there by the ANMs themselves.

The rapidly growing number of private nursing homes and hospitals in urban and peri-urban areas is an indication of the growing demand for their services. The use of these facilities, especially among young women, is rapidly increasing – first, for sex determination and second, for delivery complications like caesarean delivery. In another study, again in rural Maharashtra, about 50 per cent adolescent pregnant women reported going to a private doctor to 'confirm' pregnancy at the suggestion of their husbands or mothers-in-law. Though they did not mention a sex determination test, the private doctor they consulted was well known in the area for carrying out these tests (Barua 1998).

In more developed Indian states, it is a common practice for young women to register with a private nursing home for antenatal care when they go to their natal home for delivery. This is a precaution against unanticipated complications in delivery needing hospital services, because many private nursing homes refuse admission to cases not registered with them for antenatal care. The extent of caesarean operations in these institutions is not known, though it is believed to be high. Recent observations in cities like Hyderabad and Bangalore suggest that even in government hospitals, caesarean deliveries are increasing, with staff claiming that clients ask for them.

If one includes *dais*, as they should be, in the private sector, one finds that most deliveries do in fact take place in this sector. Various

group discussions, case studies and informal talks with *dais* reveal that they charge anything between Rs. 200 to Rs. 1500 per delivery. ANMs charge between Rs. 500 to Rs. 1000 when they conduct a delivery privately. Private clinics charge Rs. 1500 for normal deliveries and upwards of Rs. 3000 for complicated deliveries. Women therefore expect to pay for delivery, whether in private or public institutions. They usually prefer institutional delivery for their first pregnancy or if they decide to go in for sterilisation after delivery. Therefore, in states like Tamil Nadu, where having two children has become the norm, up to 80 per cent deliveries are institutional, with more than half taking place in private institutions.

One of the main objectives of the RCH programme is to increase the all-India percentage of safe deliveries from 30 per cent to 40 per cent by the year 2002. A safe delivery is defined as either an institutional delivery or a home delivery conducted by a trained midwife. In India, it is mainly the northern states that lag behind on this indicator, for several reasons including lack of awareness, fewer facilities and trained persons, low status of women, and the ignorance of men of the health risks during delivery. An NGO in Gujarat, after recognising men's role in getting hospital treatment for women, introduced a system of sending a postcard to the male head of the family, informing him about the health problem of his wife or daughter-in-law and asking him to bring her in for treatment. That idea worked. Many women, who earlier would not have come for treatment, were brought by the family to the hospital (Murthy 1991).

With the increase in the level of mass communication on women's health problems, over time this constraint is likely to be reduced all over India. As in the southern states, we are likely to witness a heightened demand for institutional deliveries in the northern states as well. When that happens, we can be sure that the private sector will respond rapidly and set up nursing homes and small hospitals to serve the market. Would developing the capacity of sub-centres, PHC and CHC contain the private sector?

There is already some case-based evidence that rural health facilities are not being used for deliveries because staff is not available around

the clock. Private nursing homes are coming up in their vicinities, where ANMs refer deliveries and even conduct them for a fee. If this is what the future holds, it is time that we began addressing issues like, should the government facilities be allowed to charge moderate fee? Should these facilities be handed over to 'not-for-profit' voluntary organisations to compete with the 'for profit' sector? Should the government think of a financial package only for the very poor, so women can avail of good quality services at places of their choice?

RCH and Gender Issues

Considerable hope has been pinned on women's involvement in providing good quality care to women and children. This hope is based on the 33 per cent reservation for women at all levels in the Panchayat system, resulting in their empowerment and increased participation in local decisions. So far, the experience in this respect has been mixed. In states where social status of women has been traditionally better, with higher literacy and greater participation in the workforce and in public affairs, women have been able to take advantage of the reservation policy. In states where these conditions do not exist, particularly the North Indian states, this has not produced much change (Pai 1998).

Women in the north have relatively little autonomy in terms of freedom of movement, inheritance rights, control over economic resources, and support from their natal home after marriage. In contrast women in south India have been better off in all these areas. The few available health indicators reflect the disparities in the levels of autonomy. In Uttar Pradesh, life expectancy is about five years higher for men as compared to women (54 and 49 respectively) while in Tamil Nadu it is 61 for both men and women. Maternal mortality ratio is over 900 in Uttar Pradesh and about 300 in Tamil Nadu. Women in Uttar Pradesh are more vulnerable and powerless and therefore suffer more from higher fertility and mortality (Jejeebhoy 1998).

In addition to lack of autonomy, their lack of knowledge and

awareness about reproductive health are other factors that determine the quality of care they get and the preventive measures they can take. But focusing on women's awareness alone is not the solution because awareness among men on whose cooperation women depend, is equally crucial. Men are traditionally supposed to be ignorant of women's problems, which are considered to be outside their domain. But, as research shows, if husbands do know about these problems, they are more likely to support their wives' decision to seek treatment and more likely to provide money and escort for it (Barua 1998).

Interestingly, though, medical technology is an unwitting partner in perpetuating gender bias. Son preference in India is well documented. Now there is ample evidence that families are abusing medical technology, such as differential contraception, sex determination tests and selective abortion to convert this preference into reality. A small but carefully documented study of rural Haryana reports on families wanting women to undergo sex determination tests. The issue of antenatal care only arose if the foetus was a boy. More and more doctors were buying ultrasound machines and transporting them to the villages by car. The only impact of banning sex determination tests in 1994 was that its cost doubled. The doctors justified selective abortion as a way to improve the status of women. The study also reported that the Post Graduate Medical Institute had decided to suspend training in mid-trimester abortion but had to restart it when the hospital started getting referrals of botched abortions from their alumni (Sabu and Dahiya 1998).

Is the RCH programme ready to deal with the issues of sex determination and selective abortion? Tamil Nadu has launched a massive educational campaign dealing with female infanticide and sex discrimination. At the same time, the number of sex determination test clinics in the state have increased manifold. As long as these services are available in private, public facilities are likely to be under-utilised.

Discussion and Recommendations

The preceding review of field-level experiences in implementing the RCH programme denotes several salient points that need attention. So far, the RCH programme has been mainly grappling with the issues of whether or not to remove targets, what to replace them with, the effect of taking such a step and how to neutralise that effect. The CNA approach has tried to deal with these issues rather well. But CNA is not the RCH programme. The experience thus far shows that it is not the target approach alone but the attitude of health staff, policies and procedures that have to be reformed.

Administrative constraints and procedural bottlenecks, which hamper the smooth functioning of the programme, need to be tackled urgently. This will require systemic reforms. The decentralised planning implied under the CNA is inadequate to deal with these constraints. In fact, CNA places planning responsibility on ANMs and PHCs, which is disproportionate to the power and resources they control. States and districts have no role in planning, though it is they who control the resources and policies. This anomaly needs to be removed. States and districts need to play more managerial role.

We also have to recognise that the RCH programme has inherited a past in which all kinds of ideas and schemes have been used as gimmicks to increase contraceptive use. Those administering this programme continue to focus on 'how to manipulate people in doing what we want'. There is no guarantee that the services packages offered in the RCH programme will not be used for the same purpose. Unless clients gain some control over service providers, the CNA by itself cannot ensure service quality and access.

The most important weakness in the RCH design seems to be the inadequate recognition of the role of the private sector. The underlying uncritical assumption is that poor people prefer public institutions to private, if the former are well equipped. But experience in all sectors shows otherwise. As the demand for RCH services increases, growth in private sector is inevitable. The government needs to develop containment strategies to deal with this. These

would include:

- developing regulatory mechanisms;
- strengthening the not-for-profit sector to compete with the for-profit sector;
- developing financial packages and community insurance only for the poor.

This is extremely important because the next strategy shift that is likely to affect the health services in the near future is the World Bank's suggestion that states should divest from curative tertiary care and allow curative services to be more or less privatised. This suggestion is based on a policy instrument currently being used called DALY — disability adjusted life year — suggesting that public expenditure should concentrate on those health services in which DALY gain is the highest (World Bank 1993). This approach may exclude the poor, the elderly and women from access to curative care (Emmel 1998).

Finally, it is important to understand that the RCH programme is still relatively new. The full package has yet to be put in place, its operational details are yet to be worked out and its implications are yet to be seen. At this stage, it is important for researchers and activists to remain vigilant, observe the field realities, and listen to the voices from below. At the same time, patience is required so that this unique opportunity to give fundamental reorientation to the Indian family welfare programme is not lost.

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*Chapter 19***Health Status of the Girl Child**

Shanti Ghosh

About 36 per cent of the Indian population is between 0-14 years of age and about one-fifth are adolescents. As per the provisional data of the 2001 Census, 15 per cent of the population are girls aged 0-6 years. The health, social and economic status of women cannot be improved without paying attention to the girl child.

The focus here is on the health status of the girl child based on a few indicators like sex ratio and mortality and morbidity rates, with special emphasis on the health of adolescent girls and the government's response to improving the health of girls.

Sex Ratio

Sex ratio, which is considered as indicative of the status of women in a society, is unfavourable to females in India and has been declining over the decades. In the 0-6 year group there are 927 girls per 1000 boys and in the seven years and above age group there are 933 females per 1000 males (Census 2001). This adverse sex ratio points to the poor health and survival status of girls and women in

the country. Female infanticide and foeticide and the deliberate neglect of the health of female children have all contributed to this decline in the sex ratio.

A baseline study sponsored by the Department of Women and Child Development in 12 major states in the country - Andhra Pradesh, Bihar, Karnataka, Gujarat, Tamil Nadu, Maharashtra, Haryana, West Bengal, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa — reveals that female foeticide and infanticide are practised specifically among certain communities. The reasons for this are the patriarchal system of inheritance and family name, strong son preference, low status of women, cost of various ceremonies relating to events in a girl's life such as celebration of attainment of puberty, marriage, birth of first child, etc. Foetal sex determination with a view to aborting the female foetus continues in spite of the laws against it, such as the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994, which has been in force since 1996.

Son preference is a very deep-rooted phenomenon in most parts of the country. National Family Health Survey (NFHS) data on fertility preferences shows that one-third women want more sons than daughters and only a negligible proportion want more daughters than sons.

Mortality

While infant and under-five mortality has registered a considerable fall in the last 15 years, it is still much too high (Table 19.1).

Table 19.1 Infant and Child Mortality		
	<i>Boys</i>	<i>Girls</i>
Neonatal mortality	50.7	44.6
Post-neonatal mortality	24.2	26.6
Infant mortality	74.8	71.1
Child mortality	24.9	36.7
Under-five mortality	97.9	105.2

Source: NFHS 2, 1998-99

More than 50 per cent of infant mortality takes place in the first month of life (neonatal) and is attributed to inadequate services for prenatal, natal and neonatal care. Malnutrition, low immunity and a combination of untreated infections, including gastroenteritis, dysentery, typhoid, malaria, influenza and unclassified fevers, are the main causes of infant deaths (Registrar General of India, SRS Bulletin, 1997).

Here, too, there is disparity between male and female infant deaths, with female mortality being higher from age one onwards, though girls are said to be biologically stronger than boys. This reflects the medical and nutritional neglect of the girl child. Studies have shown that there is maximum gender differential in the allocation of food and medical care during the first two years of life. Twice as much is spent on the medical care of male infants than on females. Male infants are also given culturally more valued foods that are also more nutritious (Gopalan and Shiva 2000).

In addition, there are vast urban and rural differences in infant mortality rates. According to the NFHS 2 and SRS data, infant mortality in rural areas was 47 and in urban areas it was above 70 (73 in NFHS 2 and 78 in SRS).

Age-specific death rates also show an increase in female mortality with age (Table 19.2). There is a greater risk of females dying during infancy, early childhood, adolescence and during prime life. As a matter of fact, female mortality is higher till the age of 30 years, mainly due to causes related to reproduction. The higher female mortality at the neonatal and child stages has a significant bearing on the sex ratio of the country, as most female deaths occur at these stages. It is therefore critical to bring down female deaths at these stages.

Morbidity and Health Seeking

Besides the six serious childhood diseases – tuberculosis, diphtheria, pertussis, poliomyelitis, measles and tetanus — acute respiratory tract infections (ARI) or pneumonia and diarrhoea are major causes

Table 19.2
Age-specific and Crude Death Rates

	NFHS 2 (1997-98)		SRS (1997)	
Age	Male	Female	Male	Female
0-4	18.1	18.5	21.8	24.5
5-9	1.8	2.2	1.8	2.4
10-14	1.0	1.4	1.1	1.2
15-19	1.8	2.5	1.4	2.1

Source: NFHS 2, 1998-99.

of child morbidity and also mortality. Though the six serious diseases are vaccine preventable, data on immunisation coverage against these diseases shows that only 42 per cent of children have received vaccinations against all these diseases, while 44 received vaccination against some and 14 per cent have not been vaccinated at all (NFHS 2 1998-99). Gender differences, though not very significant, have been observed in this context as well: more boys than girls are likely to have received all the vaccinations.

Similarly, even though the diarrhoea management programme has been in operation for several decades and the ARI programme for about two decades, these diseases continue to be major causes of child morbidity. Poor knowledge of the mothers regarding the signs of pneumonia and oral rehydration therapy further compounds the problem. The NFHS 2 found that 19 per cent children in each of the two disease categories had suffered from ARI and diarrhoea and 64 per cent of these children were taken for treatment to a health facility or provider. Again, gender discrimination in health care seeking for female children has been observed, with more boys than girls being taken to a health provider for the treatment of ARI and pneumonia.

In 52 per cent of the diarrhoea cases, children did not receive any kind of oral rehydration therapy. The key message that diarrhoea needs replacement of fluids and not drugs, is only just beginning to be accepted; a vast number of anti-diarrhoeal drugs still continue to

be prescribed and parents spend a great deal of money buying these. As the NFHS 2 found, the use of unnecessary anti-diarrhoeal drugs is widespread: 53 per cent of the children who had suffered from diarrhoea in the two weeks preceding the survey were treated with pills or syrup, and 15 per cent received an injection.

The standard treatment regime for ARI, Cotrimexazole, is supposed to be available at all outlets of health services – rural as well as urban. Yet, due to lack of awareness and lack of timely access, infants and young children continue to die of this condition. The number of deaths due to these two conditions is difficult to assess, but it could be around three million per year.

Nutrition

The World Health Organisation (WHO) estimates that malnutrition was associated with over half of all deaths in developing countries in 1995. Besides, research indicates a link between malnutrition in early life, including the period of foetal growth, and the development later in life of chronic conditions like coronary heart disease, diabetes and high blood pressure, giving the countries in which malnutrition is already a major problem new cause for concern (Barker 1994).

The risk of death for common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child, and may be as high as eight times for a severely malnourished child (Pelletier et al. 1993). Malnutrition is contributory to almost half the deaths under five years of age.

Though malnutrition is common among all population groups, it is more significant and serious in women of childbearing age and young children. Maximum malnutrition is between six months and two years of age in every state – only the extent varies (Reddy et al. 1993). It is estimated that there are 60 million malnourished children under four, of which nearly 60 per cent live in the five states of Uttar Pradesh, Bihar, West Bengal, Madhya Pradesh and Maharashtra. Two out of three preschools are severely or moderately malnourished.

According to the National Nutrition Monitoring Bureau, Hyderabad (1988-90), only 10 per cent children had normal nutrition, while 9 per cent were severely malnourished. The situation was a little better than what it was 10 years earlier.

According to the countrywide NFHS 2 (1998-99), stunting rates are 46 per cent while wasting rates are 16 per cent. NFHS data show that a higher proportion of girls are severely malnourished in 11 of the 14 large states of India.

Breastfeeding has a key role in improving the nutritional status as well as chances survival of children, as it protects the baby from infections. Breast milk is the perfect food and even malnourished mothers are able to produce sufficient amounts for their babies. Several studies have shown a high incidence of diarrhoeal and respiratory infections in non-breastfeeding babies. However, NFHS data shows that though breastfeeding is universal, only 16 per cent mothers breastfed their babies within the first hour and 37 per cent on the first day. The prevalence of other harmful practices like squeezing out the first milk, and feeding the baby sugar and lime-water or jaggery also increase the risk of diarrhoeal diseases and infections in babies. Exclusive breastfeeding for five to six months is what babies need before going on to home-cooked, semi-solid foods (Ghosh 1997), but only 55 per cent mothers were exclusively breastfeeding. The situation regarding the introduction of semi-solids is also dismal; only 34 per cent babies received semi-solid food. In large states like Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan, less than a quarter children received semi-solids between six and nine months. The situation was much better in Kerala, Goa and the eastern states. Again, gender discrimination in breastfeeding and weaning practices has been observed: boys are more likely to be breastfed for a longer duration than girls.

Apart from lack of family support to the breastfeeding young mother in the case of nuclear families, their availability for breastfeeding is also questionable if they are working. They try and cope by breastfeeding in the morning, evenings and through the night.

However, the feeding of semi-solid food is often left to someone else in the family, often the older female sibling if there is no other older female relative in the house. This responsibility deprives the girl her schooling as well a carefree childhood.

However, there seems to be light at the end of the tunnel. Nutrition status seems to be improving a little and even the prevalence of low birth weight babies seems to be declining slightly (Sachdev, unpublished data). Reports from Tamil Nadu (Rajaratnam and Sampath Kumar 1998) suggest an improvement in the nutritional level with 52 per cent normal, 28 per cent stunted and 10 per cent wasted. A study of the factors that have contributed to this improvement is therefore essential if we wish to improve the nutritional level among babies in all states in India.

The Adolescent Girl

As malnutrition among the child population in the country is widely prevalent, it follows that moderate to severe degree of malnutrition would prevail among girl children too, and continue to persist through adolescence and in pregnancy. It is a particularly serious problem among pregnant women. Anaemic mothers are more likely to have low birth weight (less than 2500 grams) babies (about one-third of the babies born in the country have a low birth weight). Not only is the death rate among such babies higher, their growth is also compromised. Anaemia is also responsible for 20 per cent of maternal deaths.

Several studies have now shown a high incidence of anaemia among adolescent girls (Kanani 1994). A large number of girls from poor households, who very likely suffer from anaemia, are pushed into early marriages, which are consummated almost immediately after menarche. Of the 4.5 million marriages that take place in India every year, three million marriages involve girls in the 15-19 years age group (UNICEF 1994). This is despite the existence of the Child Marriage Restraint Act, which makes the marriage of a girl less than 18 years of age illegal and punishable. Though the mean age of

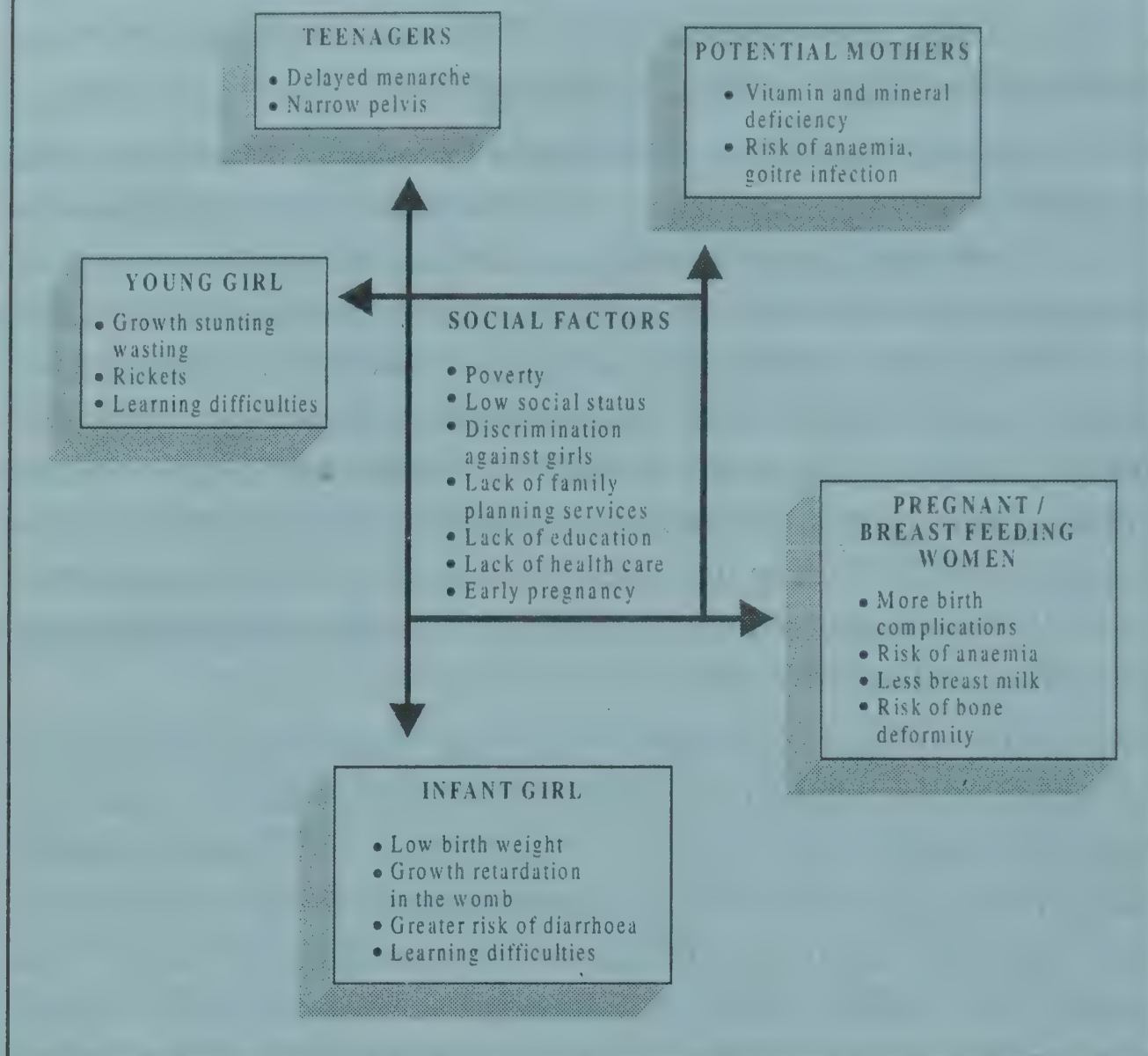
marriage of females is now 19.6 years for India as a whole, it is much lower than that in several states. According to NFHS 2, 34 per cent of women in the 15-19 years age group are already married; and the median age of marriage is still 15 years in states like Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Andhra Pradesh.

Girls who bear their first baby between the ages of 14 and 18 are at obstetric risk. According to National Nutrition Monitoring Bureau data, a very high proportion of girls who enter their fourteenth or fifteenth year of life with a height less than 145 cm and weight less than 38 kg, is at obstetric risk. As a result, low birth weight babies and perinatal complications are common among teenaged girls. The NFHS 2 reveals that infant mortality is 50 per cent higher among children born to mothers under age 20 than among children born to mothers age 20-29. The upsurge of female deaths in the age group of 15-19 years bears testimony to the high mortality rate of adolescent girls who are burdened with pregnancies at an early age.

The health of adolescent girls is closely linked with the socio-economic status of the households to which they belong and their age and kinship status within the households. In a predominantly patriarchal society like ours, girls get a lesser share in the household distribution of health, goods and services compared to boys. Food scarcity has a more adverse effect on the nutritional status of girls than on that of boys. While girls in the 13 to 16 years age group consume less food than boys, in the intra-household distribution of labour, they have the major share of economic, procreative and family responsibilities. Due to competing demands on their time and energy as well as their socialisation, girls tend to neglect their health. This continues even when they become adult women. Lower access to food coupled with neglect invariably leads to a poor nutritional status and a state of ill health in most adolescent girls (see Fig. 19.1).

In addition to poor nutrition and reproductive health risks arising from early childbearing, adolescent girls are also exposed to environmental degradation, violence and occupational hazards, all of which have implications for their health.

Figure 19.1
The Vicious Circle of Malnutrition



Source : Women of South East Asia: A Health Profile. WHO 2000

Policy and Programme Initiatives

The Directive Principles of State Policy in the Constitution of India provide for the care of women and children. India is also a signatory of the Convention of the Rights of the Child (CRC), which makes the welfare of children a responsibility of the state. India, in fact, was among the first group of countries along with others in Africa to identify the 'girl child' as the focus for improving the social and economic status of women (Gopalan and Bhaskar 1998).

At the SAARC meeting at Male in 1990, the heads of the participating

countries declared 1991-2000 A.D. as the 'SAARC Decade for the Girl Child'. Consequently, in 1992, the Government of India formulated a National Plan of Action exclusively for the 'Survival, Protection and Development of the Girl Children' (Box 19.1). The Plan recognised the rights of the girl child to equal opportunity and to be free from hunger, illiteracy, ignorance and exploitation. The Inter-Ministerial Coordination Committee of Secretaries, constituted to monitor and implement the Plan of Action, was required to meet regularly and review the progress (*ibid.*).

State governments were in turn required to formulate State Plans of Action for the Girl Child, appropriate to the conditions prevailing in their respective state. So far, only the governments of Karnataka, Madhya Pradesh, Tamil Nadu and Goa have formulated such a plan. In addition, the draft National Policy for the Empowerment of Women has laid down a policy framework for the Elimination of Discrimination Against and Violation of the Rights of the Girl Child (*ibid.*)

Universal Immunisation Programme

One of the more important areas of success in the health delivery system is the universal immunisation programme (UIP), which was started in 1985-86 to cover at least 85 per cent of all the infants against six serious but preventable diseases by 1990. Though overall coverage reached almost 80 per cent, only 40 per cent children received all vaccines. Two doses of tetanus toxoid to pregnant women have helped to reduce the incidence of neonatal tetanus to a much lower level. India has now launched a pulse polio programme for the elimination of polio, in which two doses of the vaccine, a month apart, are given to every child under three years (now increased to five years) on two fixed days throughout the country. However, because polio cases continue to be reported from various states, the number of pulses has been increased to four. This has had an adverse effect on overall immunisation coverage, with the result that some of the vaccine-preventable diseases are making a comeback. The number of polio cases reported in 2001 was 29.

Box 19.1**National Plan of Action Exclusively
for the Girl Child (1991-2000), 1992****Objectives**

- Prevent cases of female foeticide and infanticide and ban the practice of amniocentesis for sex determination;
- End gender disparity in infant mortality rate; eliminate gender disparities in feeding practices, expand nutritional interventions to reduce severe malnourishment by half and provide supplementary nutrition to adolescent girls in need;
- Reduce deaths due to diarrhoea by 50 per cent among girl children under 5 years and ensure immunisation against all forms of serious illnesses; and
- Provide safe drinking water and ensure access to fodder and drinking water nearer home.

Strategies for achievement of these objectives

- Relief for those girls who are economically and socially deprived and who belong to special groups;
- Intervention to sensitise various agencies on the need to protect the girl child and adolescent girls from exploitation, assault and physical abuse;
- Education and sensitisation of male members of the family to the special needs of the girl child;
- Equal treatment, dignity and respect for girl children in the family and community, as well as provision of support and help in their day-to-day work so that they get time to avail of the opportunities for self-development;
- Rehabilitation services to reduce the growing instances of exploitation of girl children and adolescent girls.
- Protection of girl children and adolescent girls from prevalent social evils such as dowry, child marriage, prostitution, rape, incest, molestation, etc., through appropriate legislation and proper enforcement.

Source: Sarala Gopalan and Vijay Bhaskar. 1998. 'Response of the Government to the Problems of the Girl Child', *Women's Link* 4 (3); July-September, pp. 2-6.

The universal immunisation programme needs an efficient surveillance system, which is currently lacking. And even though

the slogan – Polio-free India by 2000 – has been officially adopted, it is difficult to estimate the number of years that the programme would need to be carried out.

Child Survival and Safe Motherhood (CSSM) Programme

The CSSM programme was launched in 1992 to provide integrated antenatal, natal and postnatal care, and child health services including immunisation, detection and management of diarrhoea and respiratory infections. Since CSSM covered the whole country during the Eighth Five Year Plan, it gave some boost to Maternal and Child Health (MCH). This has now been replaced by the Reproductive and Child Health (RCH) programme, in which women's health gets much more attention. Child survival services for newborns and infants under RCH include better neonatal care, immunisation and promotion of breastfeeding, oral rehydration therapy for diarrhoeal diseases, detection and referrals of premature babies, low birth weight babies, severe dehydration, and acute respiratory infections.

Integrated Child Development Scheme (ICDS)

The goal of the ICDS Programme is to improve the nutritional and health status of pregnant and lactating women and of children below six years of age and to enable mothers to look after their children's health and nutritional needs. Under the programme, female workers provide services like supplemental food for children, pre-school programmes, and nutrition and education programmes for women, at Anganwadis (village health and child care centres). Presently covering over 80 per cent of the development blocks, ICDS is being expanded throughout the country to cover all blocks.

At present, except for some food distribution, it contains nothing practical for children in the 0-3 years age group. However, it does have some provision for development activities aimed at older children, and some studies have shown better psychosocial development in these children. Still, there is ample scope for improving these activities.

Several evaluations have shown no difference between the nutritional

status of children in ICDS and non-ICDS blocks (Ghosh 1997; ICMR 1989; Kanani 1994). If it is to make any difference in this context, ICDS will have to concentrate on children below three years and that too in their homes rather than at the Anganwadi level. Active participation by the community, which is sorely lacking at present, is of paramount importance. Vibrant women's groups could contribute a great deal to various activities connected with ICDS and help in empowering the community.

Programmes for Adolescent Girls

There are hardly any services aimed at adolescents – be they related to health, education or awareness. In 1992, an Adolescent Girls' Scheme was initiated as a special intervention for girls between 11 and 18 years of age to meet their special needs in terms of nutrition, education and skill development. Now renamed Kishori Shakti Yojana, the scheme has been extended to 1,493 blocks in areas that are especially poor in women development indices. The scheme is to be implemented in 2,000 selected ICDS projects by the end of the Ninth Plan period. It divides adolescent girls into two age groups: 11-15 and 16-17. The focus for the younger group is on prevention of child labour and ensuring school education through village-level, community volunteer-based basic education. The focus for the elder group is on marriage counselling, reproductive health issues (through workshops and exposure visits) and training in skill development.

However, as an assessment by the Department of Women and Child Development, HRD Ministry itself showed, despite it being the Decade of the Girl Child, the scheme has been a non-starter due to indifferent implementation by states. Most of the states have taken their own time in implementing the scheme in different blocks within the stipulated period. Half the decade was nearly over by the time 27 Anganwadi Centres started implementing the scheme; another 11 were added during the following year, 1995-96. In Assam and Uttar Pradesh, the adolescent girl scheme was initiated for the first time during 2001, at least four years behind schedule (*Hindustan Times* 2001).

There was hardly any effort to popularise the scheme in the community or any attempt to orient district and block-level officials through training, such as that for Anganwadi workers, helpers and representatives of NGOs. Only the states of Haryana, Maharashtra, West Bengal and the Pondicherry showed some sincerity in orienting officials towards the adolescent girls scheme.

One component of the RCH Programme is the provision of reproductive health services for adolescents and effective nutritional services for vulnerable groups. However there is no specific mention of unmarried adolescent girls. Thus, it appears that as in the case of the CSSM Programme, RCH will benefit only married adolescents.

The government has been operating an anaemia management programme for more than 20 years, but has yet to make any dent in the problem (ICMR 1989). The supply of iron tablets is erratic and their consumption by pregnant women is also irregular. Besides, the short period for which a pregnant woman is treated is not enough to make any impact. Anaemia needs to be controlled right from childhood through adolescence. Given the high incidence of early marriage and repeated pregnancies among adolescent girls, the chances of any improvement in terms of controlling anaemia are practically nil.

The Balika Samriddhi Yojana

Another major initiative to raise the overall status of the girl child is the Balika Samriddhi Yojana, launched by the government in 1997. The goal of the programme is to change family and community attitudes towards the girl child and her mother. The scheme aims to benefit about 25 lakh girl children born every year in families living below the poverty line. The first component of the scheme, which has already been launched, is to provide Rs.500 as a post-delivery grant to the mother of the girl child as a symbolic gift from the government. The other components proposed under the scheme are provision of annual scholarships to the beneficiaries when they go to school and assistance in obtaining income-generating activities when they attain the age of maturity (Gopalan and Bhaskar 1998).

Some states have introduced schemes that offer monetary incentives to girls who marry after 18 years of age. Multi-media campaigns have also been conducted in states like Rajasthan and Madhya Pradesh to create public opinion against child marriage and to mobilise social forces to prevent them.

Conclusion

Girls in India are at a disadvantage right from infancy to adulthood – higher mortality during infancy and in the reproductive age, lower access to food nutrition and health care, not to mention educational attainment. Unfortunately, they do not really experience a period of 'adolescence'; instead, they step from childhood directly into adulthood as they are married off at a very early age and becoming pregnant soon after. The health of girls determines the health of the future population, as it has an intergenerational effect. The cumulative impact of the low health status of girls is reflected in high maternal mortality, the incidence of low birth weight babies, high prenatal mortality and foetal wastage and consequent high fertility rates. As Mahatma Gandhi said, the test of human rights and human dignity is when the last among the least are empowered to realise them first. The most defenceless and voiceless are the children, especially girl children. Strategies for women's empowerment therefore need to focus on the girl child.

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*Chapter 20***India's Nutrition Policy**
A View through the Gender Lens

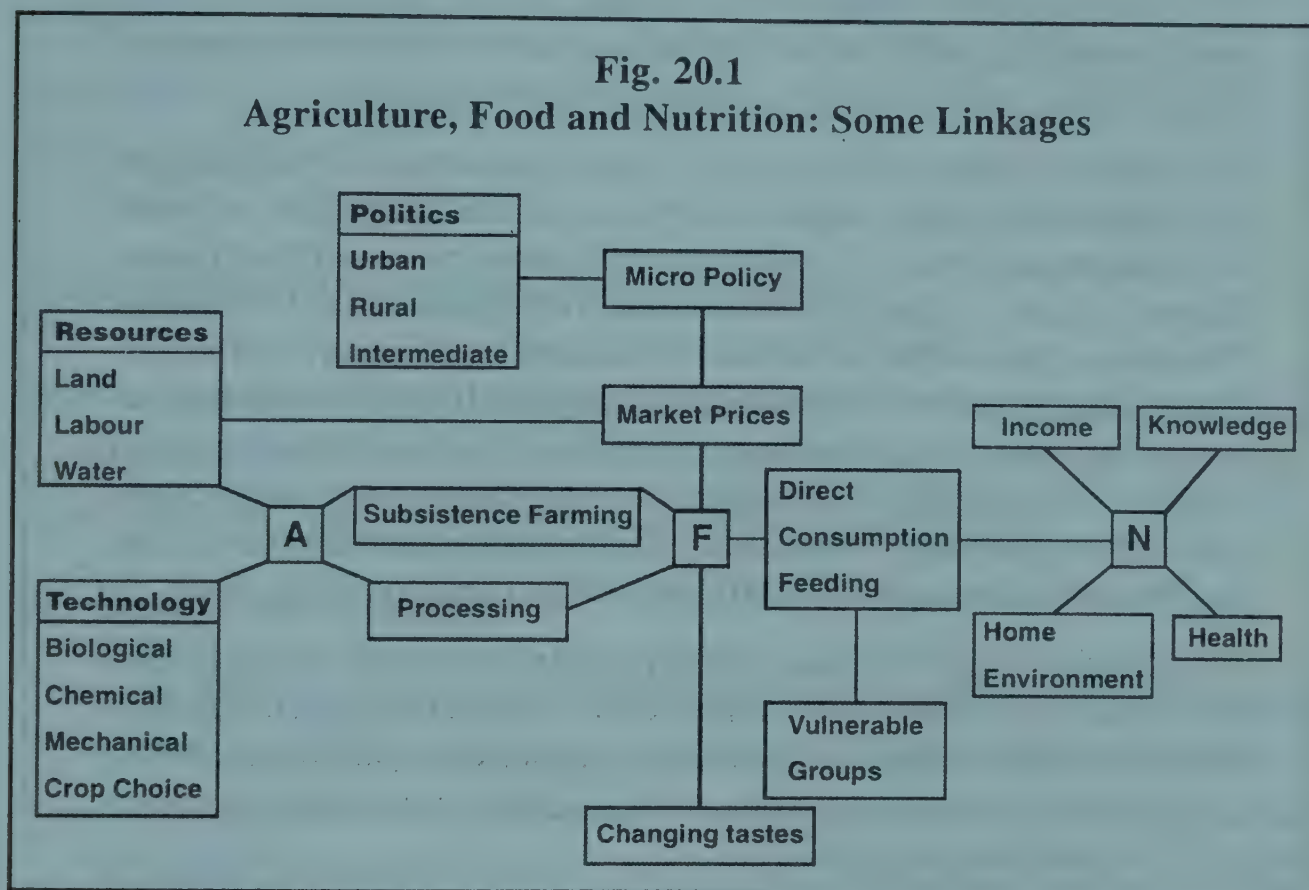
Shubhada Kanani

National policies are crucial for development as they provide the necessary framework for conceptual clarity and guide action at national and regional levels. Subsequent to the United Nations World Summit on Children in 1990 and the Global Plan of Action for Nutrition in 1992, the Government of India (GOI) adopted a National Nutrition Policy in 1993 (GOI 1993).

It is ironical that from production to consumption, women play a major role in the food chain; they are providers who take care of the entire family's nutritional needs. Yet, their own nutritional needs are often neglected. The national and state policies on nutrition therefore need to take into account gender concerns and be sensitive to the unique problems and potential of women, adolescent girls and girl children. It is worthwhile then to view the policy through a gender lens and examine its provisions from a gender-cum-nutrition perspective.

National Nutrition Policy (NNP) of the GOI

The NNP first sets itself in the context of development and emphasises the nutrition-poverty cycle. It views the problem of under-nutrition as part of a larger set of interlinked processes in the sectors of agriculture, food production/processing and distribution. Fig. 20.1 presents an understanding of these images.



Source : NNP, 1993

Comments from a Gender Perspective

It is commendable that the nutrition policy is set in the context of development and poverty alleviation. It acknowledges that

‘while the poor constitute the nutritionally-at-risk population, within this group, women and children represent nutritionally the most vulnerable sections. This is the result of intra-household gender discrimination, which perpetuates age-old inequities. Mere economic development or even adequacy of food at household level, is no guarantee for a satisfactory nutritional status.’

Box 20.1**Starvation Deaths, Overflowing Godowns**

Famine has again returned to Orissa and other parts of the country. Between July 27 and August 28, 2001, 20 deaths were reported from the Kshipur District of Orissa. Eleven children were reported dead in Udaipur in Rajasthan over a week. Earlier 800 of tribal children had died of starvation in Maharashtra.

“... The tragedy is that while people starve, the godowns are overflowing, Rs. 300-400 million is being spent daily to stock food, of which 35 percent is rotting”, said Mulayam Singh Yadav.

Starvation deaths are a direct result of the withdrawal of food subsidies and dismantling of the food security system through policies of trade liberalisation and economic reforms and the resulting rise of food prices. Farmer suicides are the result of withdrawal of regulations and the market for seeds and pesticides, as well as the dismantling of import restrictions. Trade liberalisation is leading to the globalisation of industrial agriculture and the consequent escalation of production costs and collapse of farm prices due to removal of the Quantitative Restrictions and import dumping. Distortion in trade and agriculture policy are leading to the erosion of food rights and food security of the poor.

Ensuring food rights in a poor country like India requires the protection of livelihoods, promotion of low cost sustainable agriculture and decentralisation of food distribution to reduce costs and waste.

Source : Excerpted from Shiva 2001

In the next section, it presents an overview of the nutrition status of vulnerable groups in India in terms of protein-energy malnutrition (PEM), iron-deficiency anemia (IDA), vitamin-A deficiency (VAD), iodine deficiency disorder (IDD) and low birth weight (LBW). Indirect factors affecting malnutrition such as seasonal variability in food availability, natural calamities and urbanisation are also presented.

The policy emphasises both an overall development strategy as well as a special focus on vulnerable groups.

However, when the policy presents data on prevalence of PEM and micronutrient deficiencies, including intake of calories, proteins and protective nutrients, the data are not disaggregated by gender. This

could partly be because the nutrition surveillance data generated by the National Nutritional Monitoring Bureau of the National Institute of Nutrition (NIN, which is cited in the policy) is often not presented separately for boys and girls. (Recent data and research from NIN and other institutions, however, do present a gender analysis.)

In the discussion on low birth weight, the importance of reducing maternal malnutrition is emphasised to bring down the incidence of LBW and maternal mortality. However, women's nutrition for its own sake, outside the context of pregnancy and lactation, does not find a mention.

Strategies to Combat Malnutrition

In the most significant section of the policy, the strategies needed to combat malnutrition are described in terms of *a*) short term, direct interventions; and *b*) long-term, indirect interventions.

A. Direct Interventions

- (1) Expanding programmes like the Integrated Child Development Scheme (ICDS) to address the overwhelmingly large number of mild to moderately malnourished children (above 60 per cent): children who have survived (Infant Mortality Rate [IMR] is declining) but are adding to the growing number of human resources in poor health and nutritional status.
- (2) Nutrition education for behavioural changes among mothers; for example, involving them in growth monitoring of their children.
- (3) Reaching adolescent girls: including them within the ambit of ICDS.
- (4) Ensuring better coverage of pregnant women, for example, through supplementary nutrition.
- (5) Controlling micronutrient deficiencies in children, pregnant and lactating women.

Comments from a Gender Perspective

In the direct interventions presented in the policy, gender sensitivity is missing in several of them. They could have included the following considerations:

- As regards expansion of ICDS, special attention needs to be given to the girl child. Expansion with quality assurance of services needs to be stressed.
- Behavioural changes are needed, not among the mother alone, but in the family as a whole; mothers will have little influence on family and child nutrition practices without family support.
- Strengthening nutrition services for all women is required rather than for only pregnant or lactating women. Women in old age also need attention in nutrition programmes.

However, the focus on adolescent girls is a plus point in the policy. At the time this policy was adopted, adolescent girls were on the periphery of nutrition interventions. Highlighting the critical importance of adolescent girls in the policy, especially in the context of malnutrition reduction for the reduction of anemia, perhaps provided the impetus for including this group in national programmes like those for anemia control.

B. Indirect Interventions

The policy calls for 'long-term' institutional and structural changes to:

- Improve food security – per capita availability of food grains.
- Improve dietary quality through increased availability of nutritionally rich foods like fruits, vegetables, eggs, animal foods, coarse grains and millets.
- Increase purchasing power through poverty alleviation programmes.
- Improve access of the poor to the public distribution system (PDS) and make PDS relevant to their needs.
- Link up with health and family welfare programmes, especially

for antenatal and postnatal care.

- Improve nutrition health knowledge through school curricula, communication strategies, mass and folk media.
- Enhance literacy levels, education and social status of women.
- Ensure community participation, especially by women.

Comments from a Gender Perspective

Several instances in this section seem to reflect a concern for the woman and girl child. To cite from the policy:

- *Equal remuneration:* special efforts should be made to ensure that wages of women shall be at par with that of men in order to improve women's economic status.
- *Communication:* alongside the information gap, existing social attitudes and prejudices, inherent in our milieu, which discriminate against girls and women and affect their health and nutrition, need to be countered through educational programmes.
- *Improvement in the status of women:* there is evidence that women's employment does benefit household nutrition through increase in household income, enhanced women's status, her autonomy and decision-making power. Female education has a strong inverse relationship with IMR.

On viewing the policy as a whole, several important concerns are found to be entirely missing. These are highlighted in the following section.

Men's Roles and Responsibilities for Women and Girl Child Nutrition

In the context of women's health, including reproductive health, it is often stated that men cannot be left out of the equation (WOHTRAC 1998). This is equally true for nutrition as well.

For a nutritional policy to meaningfully guide action at the field level, it needs to emphasise men's responsibilities as well as action

required to reduce malnutrition in women and girls, indeed in the whole family. This will have manifold benefits:

- Men's, or father's, support for girl child's education, food intake and care in the family will greatly enhance her health, nutritional status and self-esteem.
- Men's sensitisation to women's needs and the importance of their role will help them be more responsive and responsible in areas such as family planning, facilitating women's access to nutrition services like ICDS, antenatal care, sharing household work, being supportive during pregnancy (e.g., helping her to procure iron folate tablets), and providing monetary resources to buy nutritional foods like seasonal fruits and vegetables.

Gender, Food Security and Intra-Household Food Distribution

The success of a policy depends on the ability to correctly anticipate the individual's responses in a household to changing situations. Actual responses may differ from anticipated responses due to a poor understanding of how rights and responsibilities are allotted in households (Haddad et al. 1996). Though half the world's food supply is cultivated by women, they rarely own the land they cultivate or have a significant say in the use of resources.

The nutrition policy thus should take into account several factors and questions, such as

- How does one address the attitudes and practices in intra-household food distribution, which favour males particularly in terms of providing them nutritionally rich and more expensive foods? What about multiple decision-makers within the households (husband, mother-in-law) and their role in household food and resource allocation?
- Is the woman's role in the food chain and her contribution to household food security adequately acknowledged and supported in the policy? Multi-country research evidence indicates that

female-headed households may be poorer than male-headed households; and they therefore need special attention in food security interventions.

Malnutrition and the Life Cycle

A nutrition problem is usually the consequence of an earlier problem and the cause of a subsequent problem. The vicious intergenerational cycle of malnutrition is well known: it passes on from a malnourished woman to her malnourished girl child (Merchant and Kurz 1993). Because of their gender, girls are especially vulnerable to malnutrition and poor health in early childhood, school years and adolescence (Kannani 1996).

The policy should therefore address the issue of gender discrimination against women and the girl child throughout their life cycle. Discrimination is a major contributor to the high prevalence of undernutrition. For instance,

- Earlier cessation of breastfeeding and earlier onset of complementary feeding for infant girls, compared to boys, makes them more vulnerable to malnutrition.
- Delayed and inadequate treatment for illnesses, emotional neglect and lack of parental attention and care are reported to contribute more significantly to severe malnutrition in girls rather than deliberate food deprivation.
- Older girl siblings are entrusted with responsibility of younger ones at the cost of their own nutrition and education.
- For a girl child already attending school against cultural norms, malnutrition may contribute to poor school achievement and early dropout from school.
- Adolescent marriage and early pregnancy aggravates the girls' poor nutritional status and anaemic condition.
- Male control over women's fertility contributes to too many pregnancies, too soon and too close. A consequence is

continuous nutritional depletion of women, LBW babies and high maternal mortality.

- Too much work, too little rest and not enough food, leads to caloric imbalance wherein calorie intake is not commensurate with calorie expenditure. The result is again nutritional depletion, poor immunity and morbidity.
- Marginalisation of women in old age leading to nutritional neglect is not adequately recognised.

A comprehensive set of interventions to address the interdependent nutritional problems in the life cycle needs to be articulated in the policy.

While contextualising nutrition policies and programmes within poverty alleviation efforts is a necessary step, it is not adequate. Economic development may increase the nutritional status of families as a whole, but it will not automatically ensure the same for women and girls. Nutrition disorders like anaemia, poor weight gain in pregnancy and poor care given to girls are seen in middle to high-income families as well.

Some Concluding Thoughts

As discussed earlier, while the nutrition policy has shown gender sensitivity in many of its components, several important gender concerns have not found a place in the document. It is important to orient and sensitise programme practitioners and nutrition advocates to these concerns, so that in the operationalisation of the policy and during programme implementation, gender sensitive attitudes and approaches are adopted. Further, state-level deliberations and action in this direction are needed so that at the district and community level, women are cared for not merely as providers of their family's food and nutrition needs, but for their own nutrition and well being as well.

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Chapter 21

Indigenous Systems of Medicine and Women's Health

Shanta Shastry

In the making of life, men and women complement each other. However, a woman's unique capacity for childbearing serves to both strengthen her position and weaken it. On the one hand, she is sought to be glorified as a goddess; on the other, she is confined and restricted, construed as *abala* (without strength, helpless). In his *Ramcharitmanas*, Tulsidas describes woman as fit for being beaten and equates her with a *dhol* (drum), a *ganwaar* (ignorant person), a *shudra* (untouchable) and a *pashu* (beast of burden). Today, we find that most women are still deprived of education and remain objects of exploitation. As a result, among other things, their physical and mental health and development suffer.

Background since Independence

After Independence, women were constitutionally granted equal status with men. Since then, various laws, policies, plans and programmes have aimed towards women's advancement. From the Fifth Five Year Plan onwards, the shift in policy approach to women

has progressed from 'welfare' to 'development' and now to 'empowerment'. The National Commission for Women was set up by Parliament in 1990 to safeguard women's rights and legal entitlements. Further, the 73rd and 74th Amendments provide for reservation of seats for women in Panchayats and Municipalities, laying the foundation for their political participation at local levels. Through its various ministries and departments, the government has introduced several schemes and programmes for the all-round development of girls and women. Despite this, there still exists a wide gap between the goals and plans enunciated on the one hand and the situational reality of women on the other. Particularly in rural areas and in the informal unorganised sector, women still do not have adequate access to education, health and resources. They remain economically marginalised and politically excluded.

Health is one among the various issues addressed in the National Policy for the Empowerment of Women, which promotes meeting the needs of women throughout their life, including nutrition and basic services from infancy to old age. It links up health with many factors like education, nutrition, sanitation, safe drinking water, employment and overall economic development. All these factors bear on the health of a person, more so of women who bear children during the reproductive period of life, from about 16 to 45 years. The Ministry of Health and Family Welfare therefore has a particular responsibility to take care of women's health.

Concerned about the perceived population explosion, the government adopted various family planning measures with emphasis on controlling fertility, first targeting men and later women. Malpractices cropped up which adversely affected people's health, especially women's health. In the 1980s, the government modified its approach to family planning, combining fertility control with some additional welfare measures to protect the health of women. In addition, since the International Conference on Population Development (ICPD) at Cairo in 1994, the government has adopted a Target Free Approach (TFA) within the Reproductive Child Health (RCH) Programme.

While improvement is reflected in some of the indicators of women's

health and status, like expectation of life at birth for females, reduction of early marriage of girls, decline of birth rate and total fertility rate, the general level of women's health status is far from satisfactory. Maternal mortality is still very high. Though abortion has been legalised, access is limited for most women. On the other hand, the drop in sex ratio since 1901 continues. The incidence of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) remains high and the spread of HIV infection is increasing. According to National Institute of Nutrition, Hyderabad, in 1989-90 nearly 50 per cent of women suffered from various degrees of chronic energy deficiency and close to 90 per cent of pregnant women were anaemic. The fact that health targets are eluding us, in spite of huge financial investment, is a matter of grave concern.

It has been observed that in its schemes and programmes for women's health, the government is overly dependent on only one system of medicine – the modern Western or 'Allopathic' system. It is against this background that we discuss here the role Indian Systems of Medicine (ISM) can play in improving women's health status. Since homeopathy does not quite fall within the ISM category in the sense that it has different roots, we shall not include it in our discussion.

Role of Indian Systems of Medicine (ISMs)

There are various non-Allopathic health systems operating in India – Ayurveda, Siddha, Unani, Yoga, Naturopathy, as well as Homoeopathy (with its origins in Germany) — each with its own strengths. Generally overlooked by health planners, these 'alternative' systems are together capable of making a substantial contribution to the health care of women. In fact, the 1983 National Health Policy emphasised the need to integrate the services of practitioners of Indian Systems of Medicines and Homeopathy (ISM&H) at appropriate levels. The policy envisaged their phased integration within the modern medical services. Unfortunately, the policy has not been operationalised, although a few state governments

have initiated some *ad hoc* measures to involve ISM&H in Primary Health Care (Box 21.1).

As has been pointed out, India has a rich heritage of indigenous medical systems. Systems like Ayurveda, Unani and Siddha are time-tested and still popular and relevant in many communities and regions. It is time that ISM&H are taken seriously and incorporated in the health programmes of all states.

Box 21.1

Traditional Systems of Medicine in Kerala

In India, the state of Kerala leads in the achievement of positive health parameters. A close study is likely to show that Traditional Systems of Medicine (TSMs) contribute significantly to the health of the people. In addition to the allopathic system, Ayurveda is practised widely in the state, as are other local health traditions that are supported by the wealth of medicinal flora found in Kerala.

Not only do ISMs specifically address women's health, women themselves are naturally oriented towards ISM practices as they are inextricably interwoven with the life of communities. From their kitchens and with a few herbs grown near their homes, Indian women typically dispense remedies for day-to-day health problems in their families and neighbourhoods. They practise health-promoting traditions using available foods and seasonal recipes. Traditional routines of *dinacharya*, *ritucharya*, *swasthavritta* and *sadvritta* – 'do's and don'ts' of diet and lifestyle – have proved to be both effective and inexpensive. ISMs thus play an important role, particularly in areas where public health services have failed to reach (Box 21.2)

Maternal Morbidity and Mortality, and Safe Motherhood

Ayurveda addresses women's health during pregnancy through *maas-anumaasic garbhinicharya*, a set of dietary and behavioural practices prescribed according to the month of gestation. These practices

Box 21.2

Ayurveda and Women's Health

In Ayurveda, women's health is codified as a separate branch that also includes children's health, or *streeroga* (women's illnesses) and *baalroga* (children's illnesses). The classic texts draw out the life cycle of a woman chronologically in seven stages (*aavastha*) of infant, child, adolescent, youth, adult, middle-aged and aged (*baala*, *taruni*, *kanya*, *yauvana*, *praudha*, *madhyama* and *vruddha*). The stage of *baalaavastha* (childhood) is further divided into *ksheeradha*, *ksheerannadha* and finally *annadha* (*ksheer*=milk; *anna*=food). The health of women in adult life is dealt with along the following lines:

- Problems of primary and secondary reproductive organs;
- Reproductive tract infections;
- Diseases of the womb during the menstrual period and after menopause;
- Elements for suitability of bride and bridegroom, and compatibility in marriage;
- Right eating habits (*aahaara*), rest and exercise (*vihaara*), and habits of the mind (*vichaara*);
- Diets for different seasons and life conditions – during menstruation, in pregnancy, after childbirth, while breastfeeding, at and after menopause, and during old age.

Women's health needs and illness management are explained in minute detail. Ayurveda accords utmost importance to a woman's care during pregnancy, not only to take care of her physical and physiological needs, but also optimise her psychological and spiritual well being. Apart from this, the related system of Yoga advises appropriate postures and exercises that can help maintain body form and tone, keep all body organs functioning optimally and the mind balanced. Body care also includes systematic massage techniques (*abhyang mardhan*) and cosmetic aspects like skin and hair care. Ayurveda provides a wide range of possible permutations and combinations of plants and other substances for practitioners to choose appropriately in any season.

ISM professionals have a great deal to contribute to women's health by introducing safe medicines, effective procedures and wholesome protocols that can be applied at the primary health care level. At the same time, they can help validate the traditional wisdom and practices of local healers, including women, reversing the trend of recent decades to strip them of their healing powers – curiously enough, in the name of 'science'.

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ensure the health of both mother and foetus and are said to prevent miscarriages. If followed throughout pregnancy, the regimen supports the birth of a healthy child and safe motherhood. Post-birth practices – such as *dhuni* (exposing the mother's vulva and the infant to the smoke of *ajwaain*), the use of *dashamool quaath* and *ajwaain ark*, oil massage and warm water bath, consuming certain foods and so on – aim at preventing post-birth complications and may help reduce both maternal mortality and morbidity.

Reproductive Tract Infections and STDs

Various hygienic practices are advised which partially address factors involved in RTIs. Traditional medicines, like *panchvalkal quaath* (for cleaning the genital parts), can help prevent infections and reduce excessive 'white' secretions. Simple ISM remedies for disorders of menstruation are found to lessen heavy bleeding. In this context, healthy food habits are also given importance.

Nutrition

Women require enhanced or modified nutrition at various stages of their lives – at puberty, in pregnancy, and as they grow older. Yet in traditional households they face life-long discrimination. Excessive fasting in youth leads to deterioration of health. Girls and women frequently forego their share of food to boys and men. Such traditional behaviour needs to be changed so that girls and women can eat proper and adequate quantities of food. Healthy women give birth to healthy children. Costly 'junk' foods need to be discouraged, with promotion of nutritious traditional seasonal foods, fruits and vegetables. In this context, the Ayurvedic medicine *punarvadi mandoor*, which contains iron, alleviates anaemia in women who are pregnant, without any side effects.

Contraceptive Care

Uncontrolled fertility poses a challenge to people's health,

particularly that of women. The government's approach emphasis modern contraceptive devices and drugs, which are extremely expensive. Some, particularly the copper-T, have led to added health problems. In this context, it might be useful to see what the traditional systems of medicine can do.

The ancient Ayurvedic and Unani texts describe procedures for fertility regulation and abortion, pointing out the demerits of having many children. At present, the Central Council for Research in Ayurveda and Siddha (CCRAS) is conducting research on indigenous contraceptives. Reference to the CCRAS study findings on *pipliyaadi yog* (Box 21.3) can now be found in some of the standard textbooks of gynaecology. This research continues with participation of some hospitals of modern medicine in a project financed by the Department of Family Welfare (DFW). In a separate project, the Defence Research Institute of Physiology and Allied Sciences (DRIPAS) is investigating the contraceptive potential of *neem* oil. Apart from this, a classical Unani text is devoted to describing various simple remedies for controlling conception, to be practiced by both men and women. Hence, there seems to be considerable potential in ISMs for controlling fertility.

Box 21.3

Ayurvedic and Contraception

In the thirteenth century A.D., Bhavaprakash wrote down certain formulations for contraception. Among them was *pipliyaadi yog* – a combination of *pipli*, *vidanga* and *tankan*. For over a decade now, the CCRAS has extensively studied this medicine for its contraceptive effect in fertile women volunteers. The study has established the efficacy of a daily dose of one gram of *pipliyaadi yog* in preventing pregnancy (500 mg twice a day, starting from day one of the menstrual cycle). Furthermore, prolonged use has shown no significant toxic or side effects.

Apart from medicines, the practice of *brahmacharya* (abstinence, particularly from sexual acts and thoughts) holds an important place in Ayurveda. This is a familiar concept among Indians and during certain times of the year, or under certain circumstances, it is

practiced quite widely. Unfortunately, the custom receives little attention during deliberations on issues of sex education in various fora. The possibility of observing *brahmacharya*, integrated with modern concepts of sexual responsibility and even use of condoms, might be useful and could be promoted both for limiting the spread of STDs and HIV and for birth control.

Reproductive and Child Health

The ISMs have a lot to contribute in the reproductive health area. To some extent, the DFW has already incorporated an ISM component within the RCH programme. The discipline of Ayurveda (formally known as *Ashtaang Ayurveda*) has eight branches. Of these, '*Kaumaaryabhritya*' deals exclusively with the health and disorders of women and children. Independently, the Siddha and Unani systems also have branches dealing with women's health. The *samhitas* (Ayurvedic texts) of *Kashyapa*, *Shushruta*, *Charaka* and *Vaagbhata* deal elaborately with women's and children's health and illnesses, together with their treatment and prevention under various headings, such as,

- Menstrual Cycle Phases and Menstruation
- Fertility, Impregnation and Conception
- Pregnancy, Development and Care
- Labour and Childbirth
- Woman's Care after Childbirth
- Infant Care after Birth
- Development and Care of Children

The classic texts thus describe concerns of reproductive health arising through pregnancy (Box 21.4), safe childbirth and after-care, and the care of children of various age groups, but also pre-conception concerns.

Ayurveda holds that reproduction weakens a woman's body. Menopause is also considered to be a time of imbalance. Giving women medicinal and nutritional supplements at these stages is

therefore necessary. Herbs like *ashvagandha*, *sataavari*, *kumaari*, *ashok* and *chandan* can be used even as simple home remedies. As has already been mentioned, in Ayurveda, antenatal care begins even before conception – when and how to have intercourse, what diet to follow and what medication to take for particular problems. Specific medications help couples to conceive and promote the conception of a healthy child. During pregnancy, a wholesome diet is recommended and unnecessary medicines are discouraged. For constipation, a simple oil enema is recommended instead of laxatives.

Box 21.4

Sushruta on Pregnancy

Sushruta – the father of modern plastic surgery – could well be known as also the ‘father of obstetrics’. His thesis on the stages of pregnancy contains elaborate descriptions of the month-to-month development of the foetus, and the various feelings within the pregnant woman as her pregnancy advances.

Today, more and more women are coming out of homes, rubbing shoulders with men, advancing towards economic independence and participating in nation-building. However, most still carry the double burden of housework, which taxes their stamina and limits their time. Many women now experience even more exploitation and marginalisation due to the economic stress of globalisation. Violence against women is apparently increasing. In the midst of such contradictory and dire conditions, the ISMs can and must play a part along with other health-promoting initiatives. At the very least, Yoga can help women cope with some of the stresses and enhance their strength and self-confidence. Harnessed in tandem with modern medicine, the ISM&H can play an important role in meeting the goal of Health For All.

*Chapter 22***Draft National ISM Policy (2001)****A Critique****Mira Sadgopal**

In the year 2001, two health policy initiatives came from the Ministry of Health and Family Welfare – the National Health Policy (NHP) 2001 and the Draft National Indigenous Systems of Medicine (ISM) Policy 2001. To some extent, these initiatives reflect the reality of changes both in health status – falling sex ratios, spreading pollution, rising violence, and the teetering health status of women, children and others – and in the ‘demand’ for Indian medical services and products (both allopathic and traditional). Both of these developments are largely linked with the trend of economic privatisation and globalisation.

Highlights of the Draft National ISM Policy

The Draft National ISM Policy begins with the recognition of the paradox that, while the country’s vast unmet need of Primary Health Care (PHC) services cries out for notice, there exist widely used ‘Indian Systems of Medicine’ (ISM) that are embedded in the diverse customs of a very large section of the population.

While the potential of ISM has been recognised since Independence, it is only since the late 1990s that policy-makers have begun to appreciate its true capacities. In 1995, the government set up an independent Department of ISM and Health in the Ministry of Health and Family Welfare. Even so, the parallel, government-funded ISM infrastructure established over the last five decades has not been utilised to its full potential for implementing public health programmes and delivering essential PHC services.

Various statistical data have more than established the growing global importance of ISM and Complementary and Alternative Medicine (CAM). Despite this and the existence in India of various regulatory acts and bodies, research councils for four separate branches of ISM (Ayurveda and Siddha, Unani, Homoeopathy, and Yoga and Naturopathy) and National Institutes of ISM, there are gaping infrastructural gaps in ISM services and medical education.

According to the Draft ISM Policy, ISM has a current industrial turnover of Rs. 4,200 crores. Of this, Rs. 3,500 crores is accounted for by Ayurveda alone, with 7,000 manufacturers of Ayurvedic products: 10 units above Rs. 50 crores, nearly 1000 units between Rs.1 to 50 crores, and 6000 units below Rs.1 crore. The potential of the ISM market in India and the global herbal market is thus bright.

The 'policy' issues, 'objectives' and 'strategies' included in the Draft ISM Policy cover the following areas: financing and administration of the ISM sector, filling infra-structural gaps, orientation of ISM practitioners, medical education in ISMs, integration of ISM and health in national health programmes and services, drug standards and enforcement, medicinal plants, medicine industry, Intellectual Property Rights (IPR) and patents, revitalisation of Local Health Traditions (LHT), home remedy kits, ISM in the Reproductive and Child Health (RCH) programme, use of ISM for improving drinking water, medical 'tourism', export of ISM practitioners, accessing ancient medical manuscripts, medical pluralism (links between ISM and the modern Western system), ISM research and access to information, veterinary medicine, development of 'special areas' (for

instance, the North-East and other states that are rich in medicinal flora and fauna) and globalisation of ISM.

Comments on the National ISM Policy

When it was circulated in the latter half of 2001, the Draft Policy drew a mix of appreciative and critical comments from a plethora of sources. Among them are the JSA or Jan Swasthya Abhiyan (People's Health Campaign), Subgroup on ISM Policy,¹ the Independent Commission on Health in India (ICHI)² and the WAH! National Network.³

The initiative taken by the Ministry of Health and Family Welfare in circulating the first Draft of the National ISM Policy has been widely appreciated because

- it is the most comprehensive post-independence statement on Indian Systems of Medicine by the Government of India.
- it touches upon issues critical for upholding the 'three pillars' of the ISM sector: (a) its natural resource base, (b) its traditional knowledge base, and (c) the development of institutions to carry the Indian medical heritage forward.
- it recognises critical issues previously not addressed in policies or programmes, including: standard ISM manufacturing practice, clinical practice standards, certification laboratories, medicinal plants (demand and supply), food supplement (nutraceutical) regulation, export of ISM education, services and products, revitalisation of LHTs, and research on ISM epistemology, veterinary care and Intellectual Property Rights.
- it encourages democratic participation in policy-making by putting the draft up for public scrutiny on a website and being receptive to critical suggestions.

The JSA Viewpoint

However, the JSA Subgroup suggests that, in addition to providing website access, government should circulate hard copies of the policy

to academic and research bodies and to other interested recipients. Nevertheless, it is appreciative of the fact that the government

- acknowledges the limitations and adverse effects of the modern biomedical approach in the context of the rise of chronic modern 'lifestyle' diseases.
- gives importance to the heritage of Traditional Systems of Medicine (TSM) and their mastery over life science, accepts the experience and contributions of ISM practitioners, and intends to re-establish ISM.
- acknowledges concern over globalisation and takes a critical view of Trade Related Intellectual Property Rights (TRIPS) and its impact.
- recommends doubling the central government budget allocation for ISM, simultaneously envisioning regulation of the ISM sector.
- lists the need for public health capacity-building, intersectoral convergence of allopathy and ISM, and development of 'family medicine'.

At the same time, the JSA Subgroup is disappointed that the Draft Policy does not reflect sufficient recognition of basic needs: adequate and safe food, drinking water, clean environment and sanitation, and so on. It also fails to point out the growing morbidity from occupational hazards and to implicate faulty developmental interventions and human-made hazards in the emerging morbidly patterns. Nor does it explicitly state the role of local government or Panchayat bodies in assessing, facilitating, and monitoring ISM health care. The Draft Policy still looks to the state as the decision-maker in the health system and makes no reference to active community participation. It still sees the people as passive receivers of state-delivered health packages.

The Policy also fails to recognise the crisis in medical education (ISM and otherwise), and the need to acknowledge thousands of traditional practitioners, with the initiation of smaller appropriate

and specialised courses. It also does not seem to be motivated towards achieving the health needs of the poor and the marginalised. Specifically, it does not...

- clearly state its role towards filling gaps in the National Health Services.
- respond to ordinary people's real needs and perceptions – local traditional healers and ISM practitioners among them – towards strengthening ISM in both rural and urban populations.
- take a critical position towards vested private commercial interests in the context of 'abundant ill health', where market economics overshadow people's needs and patient's rights.

The ICHI Critique

ICHI, on the other hand, points to five concerns that it feels should be addressed in the ISM policy. One relates to the lack of creativity in the TSM community, which perhaps stems from the neglect of ISM's theoretical foundations. Strengthening the latter could reverse this trend. Another point that ICHI raises is the need to optimise the contribution of both codified/formal ISM and folk LHT streams to public health in India. This would also necessitate building up the limited role that ISM plays in shaping the current global wave of 'medical pluralism', which in turn would require generating scientific evidence that would back the claims of ISM and folk practitioners. In this context, a related concern would be to help the Indian herbal industry realise its potential to become a 'world player'.

ICHI also stresses that by definition, the term 'ISM' (or 'TSM', or 'Indian medical heritage') needs to include the codified systems (Ayurveda, Unani, Siddha, Yoga, Swa Rigpa-Tibetan) as well as India's many region- and community-specific folk health care systems and diverse ecosystems. In the development of the ISM sector, the government would need to act as a facilitator — rather than as an actor or manager — with active GO and NGO participation in all key ISM areas of research, training and extension services. The government would also need to ensure half the funds allocated

for 'ISM research, teaching and extension', are invested in NGO institutions of repute. This would serve to correct the current investment bias towards ineffective state and central GOs. Conservation and cultivation (Box 22.1) of the 'wild population' of medicinal plants through cost-effective *in situ* forest gene bank networks is as critical as the support extended to medicinal plant cultivation and needs to be systematically put in place.

Box 22.1

Need for Conservation and Cultivation

While medicinal plant conservation alone can ensure long-term availability of genetic diversity, cultivation meets immediate raw material needs. While conservation is the backbone of sustainable cultivation, cultivation reduces pressure on wild populations. Hence both need support.

The government should not guarantee to 'buy back' the medicinal plants grown by cultivators with public funds at support prices, and incur potential losses in storage and sales. Rather, it should facilitate direct buy-back guarantees from manufacturers to cultivators.

There is no need to expand the country's three existing high-tech cold storage gene banks, as they are adequate for critically endangered species that can no longer be conserved in nature.

The government would also need to ensure that the health, food security and livelihood needs of rural communities get as much support from the ISM sector as research, production and export of herbal products. Similarly, the relevant application of ISM epistemology would need to be encouraged to the same extent as collaborative research with Western biomedicine. While the Draft Policy recognises the need for research on fundamental ISM principles, it should also specify a focus on exploring 'contemporary applications' in areas like clinical research, on new drug development and adding new plants in the *materia medica*, on parameters for standardising ISM drugs and procedures, and on development of diagnostic and treatment protocols for diseases of priority in the NHP. If the quality of ISM drugs is to be optimised, the Policy must ensure

that drug standards rest on modern laboratory tools, developed to interpret ISM parameters. The plan for Information Technology (IT) applications is insufficiently spelled out. The Policy would need to provide for the establishment of databases and expertise systems on plants, herbal formulations and diagnostics to contribute to creativity and efficiency in ISM research, teaching and extension, and with respect to intellectual property rights. IPR issues need to be addressed not only for prevention of false patents, but also for promoting 'good' patents that protect innovations within the ISM community.

Tree and plant care (*vriksha ayurveda*) deserves as much support as does veterinary medicine (*pashu ayurveda*) in the policy. Since the current programme to promote 'herbal gardens' lacks substance, the ICHI recommends that the Policy makes provision for setting up a national network of *taluka* and district-level ethno-medicinal plant gardens to conserve the 'good old species' of plants known to India's ethnic communities. This should be done with the active participation of local communities. The gardens could be managed by ISM colleges, NGOs, or local Panchayats with support from central and state governments.

WAH! Network Comments

A major shortcoming of the ISM Policy according to the WAH! Network is that it fails to link up with the content and aspirations of NHP 2001. Another area of concern is that the policy as a whole lacks sensitivity to 'gender' as a factor that significantly affects ISM education, practice, research and industry. Today, 'gender' is just as important as class, caste and the 'global marketplace' as a factor in health and ISM development. ISM does not lack in offering methods for averting female births, postponing menstrual periods for spurious (or religious) reasons, or in promoting skin-deep 'beauty' for women.

The ISM Policy also does not take into account that reorientation of medical education needs to be informed, in theory and in practice, by regional variations in natural resources, textual and local traditional heritage, and residing expertise. For instance, Kerala has a rich tradition of 'internal purification' that is distinct from classical

Ayurvedic *panchakarma*. There also exist many ancient texts in the Malayalam language. However, these find no place in the new syllabus in Kerala, as it is uniform for all states.

In addition, the teaching pattern for ISM is currently the same as for the modern Western system. The scope for this needs to be widened to incorporate different methodologies that are partially drawn from ancient Indian teaching traditions. In this context, the predominance of Ayurveda over the other ISMs and over LHTs needs to be corrected and appropriate importance given to each stream of ISM. A definite plan for the revitalisation of LHT is required, including commonly owned and run village herbal gardens and pharmacies so that people have ready access to traditional primary health care materials.

The traditional *dai* or midwives find no mention in the Policy, nor is there any programme for reinstituting and standardising their training according to TSM perspectives and experience. The *dai* midwifery tradition is still highly respected in various regions – even today, *dais* and other women manage up to 80 per cent or more of births in both rural and urban poor communities.

The issue of recognition and legal sanction of local healers' practice has been entirely ignored. A great problem faced by rural healers is their lack of recognition or legal sanction to practice. Some provision is needed to give them legal status without making them so-called 'doctors'.

Inadequate Statement of Goals

While key issues and areas have been identified in the Draft ISM Policy, goals for achievement have been left unspecified. Unlike NHP 2001, which *does* spell out health goals to be achieved by 2005 to 2015, there is no linkage or even mention of these in the Draft ISM Policy.

Articulation of goals is important not only for clear interpretation of policy but also for assessing implementation effectiveness, promoting accountability of the government, which is measured by the

accomplishment of goals. Despite the fact that some of the ISM policy goals would be distinct from those listed in NHP 2001, they would nevertheless be consistent with it.

ICHI has formulated nine major goals implied in the Draft Policy document. These are:

- (1) To promote quality medical education via NGO and GO institutions.
- (2) To promote applications of ISM epistemology connected with present needs of the medical community and the public.
- (3) To promote collaborative research between ISM and Western biomedicine in prioritised areas, to foster mutual understanding and wide usage of ISM products and services domestically and globally.
- (4) To promote integration of ISM and Western biomedicine in the health services at primary, secondary and tertiary care levels.
- (5) To promote 'health security' through revitalisation of effective LHT practices and 'livelihood security' through large-scale medicinal plant cultivation and processing as community-based enterprises.
- (6) To introduce Good Manufacturing Practices (GMP) standards for Indian herbal products.
- (7) To encourage growth of the ISM Industry via private and community enterprises to 10 times the present turnover.
- (8) To promote *in situ* conservation of medicinal flora, fauna and minerals for long-term survival of the diverse natural resource base.
- (9) To prevent IPR violation of ISM by putting knowledge into the public domain in international format, and to encourage innovations by the folk and formal community by facilitating IPR system recognition.

In addition, as WAH! points out, gender and empowerment issues

of women and marginalised local communities *must be brought to bear strongly and visibly* on both the NHP 2001 and ISM Policy and in all the health programmes – otherwise fulfilment of the goals cannot be optimised. In the Draft ISM Policy the goals themselves need to be concretised by fixing specific quantitative and qualitative indicators of achievement *in every case*.

Notes

- 1 The Jan Swasythya Abhiyaan (JSA) Subgroup on ISM is a newly formed collective of concerned groups, networks and health-related professionals within the national People's Health Campaign network. It includes: People's Health Campaign (UP), HealthWatch (UP-Bihar), UP Voluntary Health Association, Bharat Gyan Vigyan Samiti (UP-Uttaranchal), Kriti Resource Centre (Lucknow), Jeevaniya Society (Lucknow), Akhil Bharatiya Sharir Shodh Sansthan, Lucknow University Departments of Social Work and of Naturopathy and Yoga.

Our critique also takes note of recommendations of various concerned fora, NGOs and persons, including the ICPD Forum (Patna, Bihar) and NGOs and intellectuals in Jharkhand.

- 2 ICHI's statement was framed by Mr. Darshan Shankar, FRLHT, Bangalore in November 2001.

- 3 The WAH! National Network (for Training and Advocacy in 'Women And Health') consists of national and regional participation, including: Aikya (Bangalore), CHETNA (Ahmedabad), LSPSS (Coimbatore), MASUM (Pune), Pragati (Pune), Sahaj (Baroda), VHAJ and Tathapi Trust (Pune), and regional programme partners in Karnataka-Tamil Nadu, Gujarat-Rajasthan and Maharashtra.

The WAH! Network takes note of the experience and critiques of other national/regional health networks, notably: HealthWatch, the Medico Friend Circle, and Shodhini. One of the WAH! partners (LSPSS) itself is a national network for supporting and developing local health traditions.

We also recognise the sharp and penetrating feminist health critique and positions stated through the Forum for Women's Health (Mumbai).

*Chapter 23***Women's Health Policies**
Lessons from International Initiatives

TK Sundari Ravindran

The 1970s saw the emergence of organised efforts by the feminist movement to demand changes in legislation, policies, programmes and services in many areas affecting women's health – abortion, birth control, shelters for battered women, rape crisis centres, and sexual self-determination – as well as other aspects of women's lives, such as economic independence. Services to meet women's health needs set up by women appeared in many parts of the world. Campaigning and service-delivery experiences during that decade led to the conceptualisation of women's health and recognition of the need to make health care women-centred and gender-sensitive. These experiences have occurred side by side with the involvement of feminists in influencing policy. In more recent years, their participation in national and global policy-making, programme design and implementation and provision of education and services has increased. Ideas emerging from the feminist health movement have influenced women working in policy, law and health services systems considerably, encouraging change both from within and outside.

We focus here on the experiences of four countries with developing women's health policies — Brazil, Australia, Colombia, and South Africa — in terms of the process of policy formulation, the factors that have facilitated or hindered change, and the lessons that can be learnt from these.

Health Policies in Brazil, Australia, Colombia and South Africa

Brazil was the first country to create a comprehensive women's health policy — the Comprehensive Programme for Women's Health Care — in 1983. The Australian National Women's Health Policy was formulated in 1988, the Colombian 'Health for Women, Women for Health' policy/programme in 1992, and the South African Women's Health Policy in 1994.

All these policies have highlighted reproductive health and sexuality, mental health and occupational health. The components of the Brazilian Comprehensive Programme for Women's Health Care were:

- Prenatal care
- Delivery and post-partum care
- Family planning services
- Breast and cervical cancer screening
- Diagnosis and treatment of STDs
- Infertility services
- Occupational health services
- Mental health services.

Further, service coverage was expanded to include adolescent girls and post-menopausal women rather than only women of reproductive age.

The Australian National Women's Health Policy document, completed in 1988 and adopted by the Commonwealth and state governments in 1989, included a set of principles that govern

women's health. It defined seven priority health issues:

- Reproductive health and sexuality
- The health of ageing women
- Emotional and mental health
- Violence against women
- Occupational health and safety
- Health needs of carers, and
- The health effects of sex-role stereotyping.

The five key action areas of this policy document were:

- Improvements in health services for women
- Provision of health information for women
- Research and data collection on women's health
- Women's participation in decision-making in health
- The training of health care providers.

Colombia's policy document, 'Health for Women, Women for Health', recognised the importance of a gender perspective in understanding health and illness, as well as poverty and other forms of inequity. It stated that discrimination against women affects their well being and that women's health status is a product of the roles and functions that they perform in society. Two major principles that guided the policy were:

- a) Women are entitled to health rights without discrimination, and
- b) Differences in women and their diverse health needs have to be respected.

The aim of Colombia's women's health policy document was to reduce inequalities between women and men, and define mechanisms to make health systems responsive to women's needs. The policy focused on five programme areas:

- Promotion of self-help
- Reproductive health and sexuality
- Prevention and care for victims of violence

- Mental health
- Occupational health
- Reproductive health and sexuality.

Instead of adopting a single policy, the South African Women's Health Policy proposed a range of policies related to abortion, violence against women, and so forth, some of which have been already adopted. The South African Women's Health Project facilitated the drafting of 13 policy proposals on the following topics:

- Environment and development
- Mental health
- Violence against women
- Ageing
- Lesbian health
- Women's health and the nursing curriculum
- Occupational health
- Cervical and breast cancer
- STDs, AIDS and infertility
- Teenage pregnancy and sexuality education
- Contraception
- Abortion
- Maternal and neonatal care.

A comparison of the policies of the four countries shows that women's health agendas have much in common, despite the widely varying social contexts from which they originate. They address the fact of gender-based discrimination and other social disadvantages imposed on women, which are a major reason why these policies are needed. They go beyond conventional medical concerns, which centre around illness management, to address issues such as violence against women, mental health, occupational health, the consequences for women of ageing, the health effects of sex-role stereotyping, ethical and political issues, as well as medical concerns.

Reproductive and sexual health continues to be the core of these

policies, not merely because women bear a greater burden of ill health from child bearing. Rather, the focus on reproductive and sexual health has emerged from the conceptualisation and articulation of women's lack of control over their bodies, their fertility and sexual lives – and therefore their health. The policies talk not just of women's health as a concern of women but also of gender equity as a concern in women's health and as an aspect of women's health policy. They recognise women's health and women's role in production and reproduction and *not merely* in reproduction.

The Process of Policy-making

In Brazil, the policy was evolved through an inclusive and consultative process. The women's movement took the initiative of drafting the technical guidelines and educational materials, and worked alongside gender-sensitive people within the government to get the programme adopted. Though the policy was implemented in 1983, the women's movement continued to promote the policy, advocate for effective implementation, implement pilot projects and train personnel.

In Australia there was a massive nation-wide consultation that lasted over two years. Over a million women, representing women from diverse backgrounds — rural and urban, across social classes and race, women in government, trade unions, health service providers, social workers (all involved with providing services to women in some way) – took part in this consultation. The consultation itself was funded by the federal government's department of health. Australia's women's health policy document reflects issues that were consistently raised by women across these varied groups.

A similar process was adopted in Colombia. A national consultation was held with the women's movement, women from the health service sector and feminist scholars. The consultation produced the analysis upon which the policy was based and the strategy for implementation was formulated along with the policy itself. Colombia's policy defined mechanisms to make the health system

responsive to women's health needs. Women's groups participated in the implementation of pilot projects of 'women-centred' and gender-sensitive comprehensive health care, in selected government health centres in three major cities.

In South Africa, 13 policy committees were constituted, each of which drafted a proposal on one topic over a period of six months. A draft policy was put together through a process of provincial networking across the country among grassroots NGOs and other women, to ensure that their ideas were incorporated into the proposals. A National Consultation was then held in 1994 to discuss and adopt a policy document, and also to ensure that those left out in the regional process were included. Province-wise groups were formed to decide on the priorities and to follow up progress, and formulate specific policies for different provinces to be implemented by committees. A coordinating committee was formed from among the members of the different committees to report back on a regular basis. The committees are still working on different projects called the Transformation Projects, where the primary health centres are being monitored to identify areas of possible change with the available resources.

Backdrop and Enabling Conditions

A significant factor that enabled the making of women's health policies in all four countries was the presence of and initiative by a strong women's health movement. International events like the 1985 Nairobi Conference on Forward Looking Strategies and the UN Decade for Women had an important role in moulding conditions within Colombia and Australia for greater receptivity to women's voices. The Ministries of Health in both these countries passed resolutions on women's health favouring empowerment of women and their participation in decision-making.

In all four countries there was a favourable political climate leading to democratisation efforts within the societies. In Australia, the Labour government was elected to power and it provided a platform

for social justice and a just society for women. Secondly, within the government, there were several women with a strong commitment to women's rights. In Colombia, the women in the Ministry of Public Health provided the necessary support for the women's health policy and in Australia, the women within the Labour Party promoted the setting up of a Ministry of Women's Affairs. They also promoted the creation of an office that would concern itself with the Status of Women in the country, and would be answerable to the Prime Minister's Office; in addition, they promoted the appointment of an Advisor to the Prime Minister on Women's Affairs. A Women's Electoral Lobby was formed to question politicians about improvements for women.

Thirdly, there was financial and technical support for new initiatives around women's health. In Colombia, the Pan-American Health Organisation (PAHO) gave considerable financial aid as well as input on gender for the formulation of the women's health policy. In Australia, the Commonwealth and the states provided increased funding for women's health services as well as for the conferences and consultations that preceded the formulation of the national policy on women's health.

The main factors that facilitated the policy-making process in each of these countries were:

Brazil

- Supportive political climate, with a government committed to social justice.
- Health care reform, which was moving towards decentralisation and addressing people's health needs.
- Presence of feminists in government.
- Action from the women's movement.

Australia

- Several decades of experience of the women's movement of running women's clinics, lobbying for changes in abortion laws

and laws related to contraception.

- A broad-based alliance with women working in service provision 'for women'; social work, nursing, churches, trade unions and government departments.
- Existence of a politically favourable climate under the Labour government (1983).
- State-level reports on Women's Health commissioned by the Labour government (1983-88) in different states. This resulted in state-funded women's health services at the community level run by elected, community-based committees.

Colombia

- An active women's health movement, with many women's groups providing health services to women.
- Presence of a number of women in the Ministry of Public Health who had an awareness of gender issues and had been promoting women's health perspectives.
- A favourable political climate; the head of the Ministry of Public Health was a member of the political Left, and was particularly sensitive to gender issues.
- The role of the Pan-American Health Organisation's Women, Health and Development Programme in contributing to an understanding of how gender roles and gender ideology impacts on women's and men's health.

South Africa

- A climate of major social transformation characterised by a highly inclusive and consultative system of policy-making.
- The overwhelming assurance that changes were imminent, that the policy process would lead to tangible end results.
- The existence of numerous community-based organisations with a leadership committed to the democratic process and achieving results.

- The leadership taken by Women's Health Project, which enjoyed the confidence of both the government sector and grassroots organisations, and was committed to seeing the process through to its implementation stage: a commitment manifested in the allocation of personnel and resources.

Implementation

All four countries were successful in implementing their women's health policies, albeit in varying degrees. In Colombia, the implementation was limited. Probably the most interesting attempt to put the policy into practice was a project conducted by women's groups in three of Colombia's main cities. The project had two main purposes: to train health providers in how to incorporate a gender perspective and reorganise the sexuality and reproductive health programmes, and to design a proposal for the prevention and management of domestic violence. This project yielded good results. The training for health care providers resulted in greater involvement of local communities, gender sensitisation, improved quality of care and changes in the physical organisation of health centres. Another outcome was the emergence of a network of organisations working on the issue of violence against women.

At the level of the government, the Ministry of Health passed some orders in 1993 to ensure universal coverage for health services by 2001, with a minimum package of services to be made available to all women, including the poorest. These included information and counselling on sexual and reproductive health, sex education and screening for cervical cancer and STDs.

The Colombian experience shows that while the policy for women's health was an important achievement, its existence did not automatically guarantee the transformation of the health system. Since the policy was a ministerial resolution and not a law, it could not be enforced. The policy has also suffered politically and budget-wise because of changes in the Ministry of Health, which resulted in a reduction in the level of gender awareness and commitment. And

finally, adequate funds were not made available for the range of activities that the policy demanded.

In Australia, the experience was far more positive. The implementation varied across the states and different models emerged. Some states concentrated on providing clinical medical services, others on upgrading nursing skills to enable nurse-practitioners to work in rural and isolated areas, while some focused on the provision of information and the development of new health resources. In some others, none of the services provided direct care; instead, they focused on counselling and group discussions on issues like disability and sexuality as well as providing information to individual women. As part of the dual strategy for mainstreaming, training was provided to health service professionals in colleges of nursing as well as those in general practice.

However, some core concepts underlie women's health services across all states. For instance, all service programmes are staffed by women trained in management and service provision. All of them draw upon women's experience in health and view health holistically. Apart from the emphasis on community based-services and the provision of information, a dual strategy principle operates to provide direct services and, at the same time, to influence mainstream service provision. In conclusion, in all states of Australia, women's health services do exist on the ground and work with women's participation to improve their health. Also, women's health planning has become a part of the broad health policy and planning infrastructure.

In South Africa, too, there has been a significant movement in the implementation of the policy proposals for various aspects of women's health. For instance, soon after the National Conference, the policy documents were distributed to key policy-makers and the heads of relevant government departments in every province. There was also a formalisation of structures for ongoing NGO and government collaboration. In at least three provincial governments, a process was created to enable the participation of health workers and users for transformation of health services. Simultaneously, there

was increased networking for a range of actions: lobbying with the government, running workshops, working together on common issues, e.g., violence against women and lesbian health.

Based on the policy documents, occupational and mental health is being given priority in certain provincial health departments. The reproductive health policy proposal is being used to restructure services. The document of violence against women has resulted in the setting up of subsidised shelters for survivors of violence. And a Parliamentary Committee has been set up to review existing legislation on the basis of the recommendations in the abortion document.

Lessons Learnt

The policy-making experiences of the four countries show that while having a policy is important, it is equally important that such a policy be developed through inclusive processes. Such a process should include diverse groups of women from all over the country rather than confine itself to just policy-makers and grassroots NGOs and women's groups. It should also cut across diverse barriers of race, class and ideology to reach consensus, thereby minimising the scope for 'derailment'. However, policy-making from the grassroots up, though highly desirable, may not be easy to achieve. First, the lack of information on the part of women being called upon to make choices and decisions must be acknowledged and dealt with. Many women do not have access to information that would enable them to make valid risk/benefit assessments regarding their own health and treatment. For example, if women are not aware of the minimum standards of care due to them or, as in the case of controversial contraceptives such as quinacrine, have not been informed about the controversy over its use, they are unlikely to demand changes. Thus, important issues may not find a place in the needs they articulate.

Second, women's health advocates and others involved in organising for change need to grapple with the ethical issues involved in mass

organisation for policy changes in any country riddled with ideological factionalism, where people's organising efforts have been consistently thwarted. Political survival in countries where political, medical and religious forces opposed to the reproductive rights of women groups are dominant, make the adoption of liberal and 'pro-women' stances difficult. In a politically unfavourable climate, attempts at organising for women's health policies may not be very successful. It is the responsibility of the leadership to help women understand the strength of the forces they are up against and the risks involved, and to strategise not only for a successful outcome, but also what to do in case of failure. At the same time, it is important not to make fundamental compromises on principles, especially on matters of women's reproductive and sexual rights, in an attempt to make short-term practical gains, e.g., in terms of some new services. There is now considerable organising experience from which these lessons can be learnt so that mistakes are not repeated.

Third, those involved in policy-making have to contend with the hard decisions involved in the setting of priorities. Being guided by women's decisions is a good principle, but it may not be enough to make allocation of scarce resources happen in a just and ethical way. The problem remains of how to strike the right balance between the common recurrent health problems affecting the majority of women versus those that are that are suffered by a minority but which are serious, life-threatening, chronic and disabling; between prevention and educational initiatives on the one hand, and effective tertiary care on the other. The magnitude and epidemiological profile of some women's health problems are well known, but there are others, equally serious, about which there is little information. Priorities can vary dramatically between localities, and policies and programmes have to allow for decentralised decision-making.

Should a country start by providing the bare minimum, to benefit at least the majority of women to some extent? Taking this pragmatic approach and pursuing a minimal package, which has to be better than nothing, poses the danger that nothing more than the minimum may ever be implemented. In a time of scarce resources and growing

tension between fiscal constraints and the pressures created by new technology, conflict between the 'economically attainable' and 'medically possible' will inevitably arise. To have to do less than what is technically possible, and putting lives and health at risk, is not an easy responsibility to shoulder. On the other hand, policy commitments that promise too much and do not deliver are also risky. When all is said and done, the needs of some women would still have to come before the needs of others. Disenchantment among those sections of women whose expectations have not been fulfilled may follow.

In all the four countries women's health policies have been successfully put into place successfully as a result of dynamic women's movements combined with a favourable political climate. The fate of these policies has, however, been very different. In Colombia, the lack of sustained effort combined with changes in political leadership impeded the successful implementation of the policy. With the adoption of a policy, a process of lobbying should therefore be initiated for its successful implementation.

Over the years following the International Conference on Population Development (ICPD) and the Fourth World Conference on Women in Beijing, the agenda has moved forward from a focus on evolving a women's health policy, to *gender mainstreaming* the health policy. This shift is based on the experiences gathered from policy-advocacy efforts over the previous decades, and the realisation that a women's health policy could result in the 'ghettoisation' of women's health projects into one under-resourced sub-unit, while it is business-as-usual in the rest of the activities of the department of health. Some services are 'added on', without fundamental changes in the way programmes are formulated and the way services are delivered.

The way ahead is to demand for the integration gender concerns into the 'mainstream' activities of the health and all related sectors. Policies, programmes and procedures need to be developed, implemented and monitored, which will ensure that equitable attention is given to the health needs of women and men (and boys

and girls), and both sexes have equal access to high-quality care at all levels of the health care delivery system. Further, issues of gender-based discrimination and inequalities within Departments of Health and in health facilities, as well as in the education and training of service providers, need to be addressed and challenged. In order for this to be possible, institutional mechanisms need to be established at various levels within the health sector — from the Ministry of Health to local health authorities - to systematically address issues of gender equity in health.

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Part 6

State Policies for Women



Part 8

State Police

to Women

Chapter 24

Maharashtra State Policies for Women

Analysis of the Old and New Documents

Lakshmi Lingam¹

The state of Maharashtra brandishes several firsts to its credit. Significant among these are the Maharashtra Regulation of the Use of Pre-natal Diagnostic Techniques Act, 1988 (to regulate detection of foetal sex), and the series of policy documents for women. One of the first documents to appear was titled *Policy for Women 1994*. Since then, new draft versions have appeared, one in 1998 titled the *New Policy for Women* and the other in 2001, titled *Women's Policy, 2001*. While the 1994 policy document was prepared by the Congress government, the 1998 document was introduced by the Shiv Sena-BJP government. The third, the 2001 policy, has been prepared by a Congress coalition government. (Here, it is worth pointing out all political parties view women as a significant vote bank). It is interesting that nearly 34 Government Orders (GOs) were passed to operationalise the 1994 document, but there is no information about whether and how they were implemented.

Here, the attempt is to highlight (a) the salient features of the new policy document, and (b) the points of agreement with and departure

from the old policy document. The significance of these documents in the light of empirical evidence and indicators of women's status in Maharashtra is dealt with at relevant places.

Features of the 1998 Policy Document

Stating emphatically that the government is keen on enhancing women's status by empowering them, the document gives special attention to law, economic programmes, education and health.

Salient Points under 'Law'

With regard to legal measures, the document proposes

- To set up more Family Courts; in the interim, regular courts are to devote one day in a week to deal with cases of marital discord, divorce, etc.
- To address and deal with sexual harassment at the workplace.
- To eliminate the upper limit for alimony, but fix a lower limit. Further, to deduct alimony from the ex-husband's salary at source.
- To change adoption laws to provide natural parenthood to the adoptive mother and father.

Salient Points under 'Economic Programmes'

The organised and unorganised sectors are dealt with under separate heads in this section.

In the organised sector the document proposes

- To ensure continuity of service of working women who take a break due to pregnancy and infant care.
- To create ease of entry into the labour market by increasing the employment age limit for women.
- To provide crèche facilities in the premises of Municipal schools.

While the earlier two points make good sense, the third raises several

questions. What about ensuring crèche facilities at women's other workplaces? Or community-based crèche facilities that are supported by sectors that hire women? Many important aspects such as declining work opportunities, provision of support structures for working women, and training opportunities for women to attain mobility have been completely left out from the document.

In the unorganised sector

- To encourage home-based self-employment as an important economic activity for women.
- To set up a Kamadhenu Scheme to help women earn while at home as, according to the document, many women cannot go out of their homes.
- To promote utilisation of women's skills at home by both public and private sectors.

The assumption here that women stay at home is incorrect. Only some sections of the urban and rural middle classes live and work exclusively in the home or private domain. The vast numbers of poor women and many educated women in service or pursuing careers are enmeshed in the public domain. Therefore, this policy priority is of limited scope.

- To disseminate information and form women's self-help groups with the help of district-level *mahila sahayoginis* and village-level anganwadi functionaries, for economic empowerment of rural women.
- To increase the honorarium paid to the anganwadi functionary in view of her involvement in economic programmes over and above women and child health programmes.

However, we note that women anganwadi functionaries continue their struggle for recognition as 'workers' and payment of salaries in the place of honoraria. Otherwise, the issues of women's multiple work roles, domestic drudgery, unequal gender division of labour, technologies that displace women, needs for training and credit, occupational health hazards, security of a living wage and so on, are

not included in the document.

Salient Points under Education

Typically, the positive benefits of women's education are listed as raising their self-confidence, increasing the age at marriage to limit family size, and improving their chances of employment in the organised sector. Measures to achieve this are given under different subheads:

Adult education: To run the adult education centres with the involvement of anganwadi centres and *mahila mandals*; and to impart information on topics such as personal hygiene, water storage, latrines, identification of common illnesses and use of home remedies, and women's property rights.

Primary and secondary education: To provide special tuitions to girls who have dropped out of school; to extend scholarship stipends for girls in Class V and above; to impart sex education and information on moral hygiene at girls hostels; to provide economic aid to families living below the poverty line for educating their girl children.

Local monitoring: To seek collaboration from *mahila mandals* and 'village education committees' for ensuring the performance of primary education and literacy work.

Technical education: To increase the seats in technical courses reserved for girls. To construct more girls' hostels and to offer them more scholarships by raising a scholarship fund from industrialists.

The stated educational measures reflect the document's fragmented and limited approach to women's and girls' education. Issues of quantity and quality of education, the increasing privatisation of education even at the primary level, irrelevance in the curriculum, lack of opportunities to maintain reading and writing abilities, parental apathy towards girls' education, the reality of sexual abuse and violence which girls and women face – none of these have

contributed to an analytical background for these policy formulations.

Salient Points under Women's Health

Taking its cue from components in the Reproductive and Child Health (RCH) Policy, this section highlights the importance of 'healthy mothers' and child health and welfare, seeking:

- To improve male involvement and responsibility by providing for paternity leave.
- To evolve an approach to lower maternal and infant mortality.
- To educate people about factors that determine foetal sex, with special modules.
- To train traditional birth attendants for healthy and safe deliveries.
- To promote the all round health (physical and mental) of adolescent girls and boys.
- To widely impart knowledge of STDs/HIV/AIDS to vulnerable women, especially in slums and among *adivasi* (Scheduled Tribe), *dalit* (Scheduled Caste) and *devadasi* communities.
- To expand the ambit of the Integrated Child Development Scheme (ICDS) to new districts.
- To impart knowledge on healthy food habits throughout the life cycle.
- To generate a debate about the population problem in the state.
- To give priority in water and sanitation programmes to women-headed households.
- To construct public baths in cities and villages.
- To construct separate toilets for boys and girls in schools.

Despite the rhetoric that women's health needs to be viewed beyond their maternal role, the policy statements fail to live up to this. The RCH programme has important new components to be included in the constellation of Family Welfare services. However, women's

health will remain a distant dream if RCH is not integrated into a comprehensive health care package that is sensitive to women's status-related issues.

The training of traditional birth attendants, important though it is, would only partially address the issue of untrained attendance at birth. Empirical evidence indicates that in many areas, most of the home births are attended only by female relatives and not even by untrained *dais*. Identifying 'at risk' mothers, safe childbirth practices, crisis or distress in childbirth, benefits to the woman of early breast-feeding, healthy infant-feeding practices, etc., need to be designated as community issues, in the same way as drinking water and sanitation.

Issues such as the resurgence of communicable diseases, support that the state needs to provide to HIV positive men and women, rural poverty, male migration, and the STDs/AIDS disease burden in the villages are completely out of the document's purview. Maharashtra is considered to be leading in the number of HIV-positive persons. It also has a large single-male migrant population in urban areas and at least three districts endemic for male migration. Health and survival issues of aged people and people with different disabilities are also prominently absent from the document.

Comparison of the 1994 and 1998 (draft) Policy Documents

The 1994 document came in at a time of structural adjustment, when globalisation and liberalisation were being advanced by the state as inevitable and irreversible. It therefore echoed the language of neo-liberalism and utility-maximising individualism through the development of women's special economic agency. The new (1998) document, on the other hand, emerged in the post 73rd and 74th Constitutional Amendment period and at the time of the UN Conference on Women, Peace and Development held at Beijing. The economic agenda had not changed, although the party in power had. However, the social and political context had deteriorated, throwing

up dubious constructs of what constitutes 'national identity', 'Indian culture', 'religion' and their representations. Communalism and fundamentalism of all hues had begun taking deep root.

Oblivious of this background, the new document is pitched in a decontextualised terrain, with no reference to the socio-economic and political scenario. The differential positioning of women, particularly in terms of caste, class and religion, is inadequately articulated. An occasional reference to *advasi* women, slum women, rural women, *devadasis* and sexually exploited women may indicate an element of sensitivity to social inequalities: however, references to these categories come in conjunction with STDs and AIDS.

In a piece-meal fashion, the document essentially spells out a statement of intent in the form of a few ideas and schemes to be implemented in the next two years. Expected difficulties in implementation have also been acknowledged, but without any analysis of the reasons.

Common Contours of 1994 and 1998 Documents

Both documents are replete with terms and phrases like 'development', 'welfare', 'empowerment', 'providing an enabling environment for women', 'women-centredness', 'participation', 'collaboration' and so on. Poor women are made out to be efficient or promising managers of poverty. It is ironic that, while the conditions of poverty are not alleviated, women are targeted through schemes to 'manage' it.

In the given context of globalisation, issues of employment security, safe work conditions, living wage, etc., have been replaced by an emphasis on 'efficiency' to be achieved through *self-help, self-employment, entrepreneurship, micro-credit and micro-enterprise*.

Fitting in with the development sector jargon of *democratic decentralisation, civil society's role, institution-building* and so on, change agents have now been discovered in the community – in village-level committees and women's groups. All of this facilitates

the rolling back of the state, while at the same time, increasingly making development a 'social' issue rather than an economic or political one.

Apart from occasional references to *adivasi* and *dalit* women, women-headed households and women of vulnerable groups, the both documents tend to treat women as a homogenous group.

Differences between the Documents

The 1994 document addressed eliminating violence against women, ensuring quality through law, improving the economic status of women, appropriate use of media, increased participation of women in local self-government and enhancing community participation in government activities. The 1998 draft focuses only on law, economic issues, education and health.

While the 1994 document introduced the concept of 'flexitime' for working women in the organised sector – which received mixed reactions – the 1998 document did not touch the issue. Rather, it positioned home-based self-employment as important. This makes 'sound economic sense' in the liberalisation environment where production is steadily shifting from the 'public' to 'private' domain.

Women's Policy, 2001 (draft)

The Government of India has declared 2001 as the women's empowerment year. The Maharashtra government released another draft women's policy in this year. Unlike the earlier policies that make reference to the Constitution of India and equality for women, the preface to this draft cites the context of CEDAW (The Convention on the Elimination of all Forms of Discrimination Against Women), the Beijing Conference, the Vienna Declaration and Human Rights. Nevertheless, the salient aspects of the draft document are flavoured with a curious mixture of protectionism, rights and empowerment language.

However, the positive aspect of the document is that it has devoted

an entire section to identifying possible sources of funding for women's empowerment. The earlier ones were silent on this crucial subject.

Salient Features of the 2001 Policy

Women's Empowerment

Women's empowerment is sought through incorporating women's empowerment measures in the plans of all government departments and other organisations. The planning process is to be undertaken with the active participation of women and funds to departments and organisations are to be linked to the inclusion of women in the plans and their implementation. Salient features include:

- **Women-focused planning:** All departments are required to plan policies and schemes for women's empowerment with the active participation of women. The state government is to move the Union Government to suitably reflect the contribution of household work in the national income statistics. Regular evaluation of the health, education and social sectors are to be a part of the planning process.
- **Charter for women:** The 'Charter for Women's Empowerment' incorporating specific proactive measures for empowerment of women is to be adopted by all government and semi-government institutions, local bodies and other organisations promoted, licensed, recognised and assisted by the government. Grants/permissions to organisations is to be linked to the charter and its implementation
- **Funding for women's empowerment:** Ten per cent of the revenue receipts of urban bodies minus committed expenditure are to be spent on the welfare of women and children. Unspent balances can be carried forward to the following year. Institutions such as cooperatives, market yards, educational institutions will also be required to earmark funds for the welfare of women and children.

- **Gender audit:** A gender audit of various departments, institutions and organisations is to be conducted through an external agency.
- **Participation:** The state will support 30 per cent reservation for women in the Parliament and State Legislatures. It will also encourage representation of women in cooperative, educational and other aided and non-aided organisations through the amendment of Acts or a policy of giving preference in registration, recognition and funding to institutions having at least 30 per cent women members.

Economic Development

In this section the thrust is on development of livelihoods in rural and semi-urban areas through:

- Economic development of women by promoting self-help groups (SHGs), with a focus on tribal women and women belonging to schedule castes, families below the poverty line and rural women. Production and marketing assistance is to be given to SHGs and a Mahila Kosh established to support them.
- Fifty per cent of research and extension efforts in rural areas are to be focused on women. Women's groups are to be assisted in taking up activities of contract farming, farm services, processing and marketing of farm produce and of starting dairy and poultry cooperatives.

Education

In the area of education, the focus is on compulsory primary education and promotion of literacy and vocational education for girls. Salient features include:

- Promotion of literacy is to be intensified, with SHGs serving as an important instrument for this.
- Enactment of a uniform Primary Education Act for compulsory education. Schools are to be started in areas where sugar factories are located in order to prevent a break in the education of

migrant labour.

- Efforts to further vocational education.
- The government is to enforce provision of various facilities to girls in schools, such as sanitation and medical facilities. Funds are to be linked to the provision of such facilities.
- Concrete steps are to be taken to promote the participation of women in sports.

Health

Efforts in promoting a health package for women are to focus on such issues as:

- Strengthening First (wrongly mentioned as 'family') Referral Units in health institutions.
- Promotion of nutrition education, nutrition gardens and backyard farming, to deal with anaemia among women.
- Regular supply of iron and folic acid capsules, timely vaccinations, promotion of institutional delivery and training of *dais* for home delivery.
- Provision of special health services for women above 40 years of age.
- Enforcement of the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act.
- Provision of ambulance facilities.
- Schemes to prevent children of HIV-affected mothers from contracting the disease during and after pregnancy.

Apart from these the policy also highlights the importance of:

- Sanitation facilities, water supply schemes and programmes for the availability of fuel, such as farm forestry and biogas.
- Public sanitation facilities and crèche facilities in public places, markets, at various commercial, industrial and other places where women work, including in villages.

- De-addiction by closure of liquor shops on demand from more than 50 per cent voters, promoting de-addiction through outreach programmes of de-addiction centres and promotion of women's vigilance committees at district and police station levels for prevention of illicit distillation.
- Restraint of child marriage through various measures like disqualifying responsible parties from government jobs or benefits, sensitisation programmes, compulsory registration of persons performing marriages, verification of age by marriage services providers and prohibiting office-bearers and workers of political parties from attending child marriages.
- Security and protection through measures including, among others, the enactment of a Women's Protection Bill; a programme to prevent trafficking and sexual exploitation; enforcement of the Dowry Prohibition Act and initiatives for protection against sexual harassment; help lines for women in distress, establishment of Women's Protection Cells, and implementation of plans for the protection of women prisoners.
- Hostels for working women, college students and other needy women and government guesthouses for visiting women employees and public representatives.
- Rehabilitation of women in distress through preference in government schemes and programmes and construction of shelters.
- Programmes for gender sensitisation of people's representatives, employees of various institutions and awareness programmes on women's welfare and development for the public.

Some Observations

The 2001 draft policy document does not depart significantly from the 1998 draft in terms of the areas covered. Compared to the 1994 policy and 1998 draft policy, the 2001 policy is disjointed and brief. The 1998 and the 2001 drafts do state the necessity to review

progress of implementation. However, the 2001 draft does not place on record the performance of the state on various promises that were made in the 1994 and 1998 draft documents. While each version of the document reiterates many aspects mentioned in the earlier documents, and drops some important areas of concern, there is also a fresh sprinkling of new terms every time. The 2001 document mentions 'gender audit' by an external agency of various departments, agencies and organisations. This would be an extremely useful exercise if it can be undertaken at the earliest. The policy is silent on issues of mental health, increasing communal tensions and their impact on women, range of legal issues that require reforms from a gender perspective, gender-sensitive guidelines for disaster or rehabilitation programmes, girl street children and support to HIV positive women and girl children. The suggestion of developing schemes to protect children of HIV positive mothers from transmission during pregnancy and delivery seems extremely naïve and inadequately thought out.

Conclusion

Seemingly progressive, the women's policy documents do provide spaces for lobbying and advocacy at one level, but they constrain options at another. The language of the documents also signifies the evolving political culture and economic priorities of the state. They also lack conceptual clarity and empirical correctness. Further, either by design or default, their silence with regard to monitoring mechanisms and indicators has contributed to non-assessment of the policy either by the state or by the women's movement.

Though consecutive governments have seemingly indicated their intent to deal with women's empowerment, in the final analysis a lot of it is lip service. The litmus test of their commitment would be the budgetary provisions and financial allocations they make for women's programmes. In this period of adjustment and reforms, allocations to the social sector, described as the 'soft' sector, are being compressed. Many of the programmes in this sector — drinking

water, sanitation, HIV/AIDS, Reproductive and Child Health, etc., are being run with bilateral or multilateral funding or through World Bank loans. This has its strengths and weaknesses.

The past one-and-a-half decades have also witnessed a decline of the state from its number one position in terms of being an investment destination. Mumbai, the capital of the state, has changed its profile from a manufacturing to a financial and services city. This also meant lot of changes in the survival and livelihood strategies of people in this city. The efforts of successive governments have been towards infrastructure development and the opening up of various sectors for private investment, so as to ultimately make Maharashtra the destination for international capital. Successive governments are also facing growing communalism on the one hand, and people's movements against large dams and power sector reforms on the other.

Meanwhile, the Maharashtra government had passed a Population Policy in the year 2000, close on the heels of the National Population Policy. There were proposals to introduce a compulsory two-child norm. Punitive measures like non-allocation of food grains for the third child and disqualification of women from standing for elections were considered, but were withdrawn amidst wide-ranging protests from women's groups and NGOs. Many of these measures smack of an anti-women and anti-poor mind-set of the government. The present government has prepared a draft bill entitled *Maharashtra Protection of Women Bill, 2001*. This, apparently, is a bill that provides for special and expeditious measures to protect women against violence, particularly in cases where they are constrained by social taboos and notions of 'family honour' from seeking external help. The government must be aiming to bag another first to its credit!

Women still have a long way to go in terms of improving their negotiating skills, increasing their political spaces, occupying decision-making spaces, carrying out an assessment of budgets and in playing a watchdog function. Passing a policy in favour of women only marks the beginning of a struggle to ensure that the policy, irrespective of all its limitations, takes a live shape. It is, however,

apparent that this is an item that is missing in the women's movement's agenda.

Notes

- 1 I deeply appreciate the inputs received from Dr Mira Sadgopal and Dr Flavia Agnes towards the earlier versions of this paper. The usual disclaimers apply.

Chapter 25

The Andhra Pradesh Women's Policy and Women's Health Policy

A Review

M. Prakasamma

A combination of several socio-cultural and political changes prompted the decision of the Andhra Pradesh government to announce a Women's Health Policy. Though the policy was announced only in 1996, a number of factors led to its rapid decline. In order to place the development and demise of the Andhra Pradesh policy on women's health, it is appropriate to review the political situation in the state during the last five years of the 1990s.

As a result of the December 1994 Assembly elections, the state government at that time was headed by a new and popular Chief Minister, N. T. Rama Rao. As promised in his election speeches, and in response to the massive movement against liquor by women, he introduced prohibition of alcohol in the state immediately after taking over the reins. However, in less than a year after assuming office, he was ousted by his son-in-law, N. Chandrababu Naidu, who became the Chief Minister of the state in September 1995.

Women's Movement and Developments

The anti-liquor protest, which started in a village in Nellore district in 1993, soon became a spontaneous mass movement all over the state involving large-scale mobilisation and organisation of women. Several women's groups and activists soon joined the movement and helped in providing a direction for advocating not only for an anti-alcohol legislation but also for overall gender equality and women's empowerment. With support from the media and political parties (the Telugu Desam Party [TDP] and the Left parties), the movement was sustained in coverage and intensity for more than a year. There was also a supportive international environment for women's activities as the International Conference on Population and Development at Cairo had just concluded. The Fourth World Conference on Women at Beijing and the pre- and post-conference debates and discussions kept the issue of gender equality and women's empowerment alive. This was therefore a period of maximum visibility to women and women's issues due to the extensive media coverage of these meetings and discussions.

The success of the women's movement, which resulted in government action and introduction of prohibition, encouraged women activists and supporters to advocate for a better deal for women in the state. The change in political leadership at this time was thus critical and conducive to the introduction of a policy on women. The factors leading to the policy on prohibition forced the state policy-makers to appreciate the importance of women voters. The time was perceived to be ripe for pro-women policies and programmes and several of these were launched.

Reservations for Women

Prior to the 73rd Amendment to the Constitution, women in Andhra Pradesh had 9 per cent reservation in elected bodies at the Mandal and Zilla Praja Parishad levels. After the amendment, however, there was an increase in the number of women elected as presidents of the Zilla Parishad and Mandal Praja Parishads between 1986 and 1992.

In the March 1995 elections to local bodies, held after the N. T. Rama Rao government came to power, one-third of the Panchayat members were women. In every district, the grassroots base of elected women members and women's leadership increased. In the newly formed Panchayats, there were 6,506 women *sarpanches*, 364 Mandal presidents and seven Zilla Parishad chairpersons. Many of those who had participated actively in the anti-alcohol movement were elected. Thus, a critical mass of women's representation became a reality. Though initially hesitant, non-vocal dummies of their male family members or political guardians, many of the elected women soon came into their own and started exercising their rights and carrying out their responsibilities in the Panchayat system.

Efforts to consolidate the broad-based grassroots support and gain approval therefrom continued even after Chandrababu Naidu took over as head of the government. The Chandrababu Naidu government introduced a series of measures to bridge the gap between the government and the people.¹ Along with grassroots activities, policies were formulated and strategies designed for overall development in other spheres. Of these, the Andhra Pradesh State Policy on Women was the first to be introduced. A Steering Committee on Women was formed with well-known women as members. Responsible for formulating the women's policy, the Committee constituted several sub-committees to deal with each key issue and came out with a policy document that was released in 1996.

The Women's Health Policy Statement and implementation strategy were part of this overall women's policy. The document was presented and opened for debate and discussion at a state seminar to which experts from all over the country were invited.

The policy, however, suffered a premature demise due to several problems, the foremost among them being flaws within the statement itself. Since it was difficult to achieve consensus among the various stakeholders, the Steering Committee soon became dysfunctional. The conception and development of the Andhra Pradesh Population Policy quickly took precedence and its formulation, printing and dissemination became the main focus of the state.

Policy Review

As mentioned in the preceding paragraph, a detailed review and retrospective analysis of the Andhra Pradesh Women's Health Policy document shows several problems in its conception and design. Not only does it contain unrealistic objectives, the policy statements and the strategies outlined for implementation are also internally inconsistent and shaky.

Unrealistic Objectives

The policy aimed to reduce maternal mortality to 100 by the year 2000, which was unrealistic, not only because there has been little research on maternal mortality and morbidity in the state but also because the National Family Health Survey (NFHS) of 1992 showed the maternal mortality ratio for the country as 437 per 100,000 live births (IIPS 1995).² A drastic reduction in just a few years was highly unlikely.³

The second goal of improving the sex ratio by 10 points, again by the year 2000, was also over-ambitious, because it meant taking it from 972 to 982 as well as counteracting the steady decline in sex ratio from 1961 to 1991.⁴ As in the rest of the country, in Andhra Pradesh, too, differential mortality levels for boys and girls start in infancy and childhood itself due to preferential treatment of boys. According to the 1991 Census figures for sex ratio, there were 9.5 lakh 'missing women' in Andhra Pradesh (Table 25.1).

Internal Inconsistencies

Whatever the stated objectives of the policy, its true intention quickly becomes clear as one reads the document. Though it does not mention population control, the intent is implicit. This becomes even more obvious when one considers the very first sentence of the state's Population Policy.⁵ The Chief Minister's foreword starts with the observation: 'Population control remains the most challenging task before our nation and our state today.' In the following paragraph, he says, 'Fertility reduction is at the heart of the development of the state' (Government of Andhra Pradesh 1997). However, statistics

Table 25.1
Sex Ratio of Andhra Pradesh and India
(Census of India)

Year	Andhra Pradesh	India
1901	985	972
1911	929	641
1921	993	955
1931	987	950
1941	980	945
1951	986	946
1961	981	941
1971	977	930
1981	975	934
1991	972	927
2001	978	933

indicate that Andhra Pradesh is in a demographic transition, with declining fertility and mortality rates and the population moving towards adulthood. The median age of the population, which was estimated at 22.3 years in 1995, is expected to increase to 32.3 years by 2020 (Hanumantharao et al. 1998).

In addition, the Women's Health Policy is fragmented and emphasises only certain health components. There is no scope for comprehensive and basic health. Nor is there any room for incorporating women's perspectives in the health services. The following are a few examples of internal inconsistencies in the policy document:

- Quality is stated to be an essential aspect only for family planning services and not for other health services. Even for family planning services, the implementation strategy is vague.
- The policy statement refers to strengthening of midwifery services, but the implementation strategy does not mention this

aspect at all.

- Similarly, the implementation strategy states that every case of maternal mortality shall be identified and analysed, but it does not provide for strengthening of services to support this.

The Women's Health Policy appears to be too ambitious in its statement and strategies. Several of its proposals seem to be unrealistic in the current context. For example, it proposes to convert 450 Primary Health Centres (PHCs) in the state to Women's Health Centres, with provision for twice weekly visits by a paediatrician and obstetrician gynaecologist. It also proposes training of Women's Health Groups in each village PHC; weekly clinics to be conducted in every village; and the presence of a fully qualified nurse-midwife and public health nurse in every *mandal*.

Towards a Comprehensive Women's Health Policy

The role of public policies is to redress the balance in favour of the underprivileged and marginalised sections of society, in this case women. The inequalities created by an unjust social system are often corrected by a positive and facilitative policy (World Bank 1995). Therefore, it is expected that a positive women's health policy formulated by the government would attempt to address the inequities in health care due to poor access and availability of health services to women, facilitate effective utilisation of these services and neutralise over-technical or biased health technology and health services.

What then should a comprehensive Women's Health Policy contain? Definitely, clear policy statements and measurable objectives. It should also contain in detail the strategies for implementation and ensure that these are commensurate with the objectives. The tone of the policy should be towards gender equity and redressal, equal opportunity and measures for facilitating the availing of that opportunity.

Though women are most vulnerable and require specific and life-

saving services during the period of maternity, it is well known that maternal health services have come to be equated with women's health services in most parts of the developing world. This approach encourages a narrowing of women's health services to converge at the time of pregnancy and childbirth and therefore reducing importance of, and even neglecting, women's general health problems. Even within the maternity phase, women's health problems are ignored, whether related to pregnancy or not. Women suffering from tuberculosis, malaria and other disorders require special attention because of their lower level of nutrition and heavier burden of work. However, though there are national programmes with a huge infrastructure in place for fighting these diseases, no special attempt is made to coordinate these with women's health services.

Incorporating the life cycle approach to women's health into the general health care delivery system would be more appropriate than concentrating on maternal health services alone. A positive and holistic policy for women's health would contextualise maternal health services within a comprehensive approach to women's health.

The following are some of the issues that need to be seriously considered for inclusion in a comprehensive women's health policy.

Sex Differentials in Morbidity and Mortality

Just as in the rest of India, though mortality is lower in female infants as compared to male, the mortality levels in Andhra Pradesh are reversed in the toddler and preschool child category. Child mortality is 28 for girls and 17 for boys. There is a higher percentage of undernourished girls than boys. This needs to be actively considered when formulating measures to redress the balance of numbers in male and female populations and finding 'the missing women'.

Both the National Family Health Surveys (NFHS 1 and NFHS 2) show that fewer girls than boys are taken for treatment when they have diarrhoea, cough or fast breathing.

Service Availability, Accessibility and Utilisation

Accessibility and availability are two critical factors that hamper

Table 25.2
Sex Differentials in Key Indicators (NFHS 2, 1998-99)

Indicators	Female	Male
Sex Ratio		
Urban	954	1000
Rural	995	1000
Infant Mortality	69	73
Child (age 1 to 4) mortality	28	17
Under five mortality	95	88
Percentage of children undernourished		
Weight for age	40	35
Height for age	40	37
Weight for height	9	9
Percentage of children immunised		
against all six diseases	63	54
against none	4	5
Percentage of sick children taken to hospital for		
Diarrhoea	64	73
Cough and fast breathing	66	72

utilisation of health services by women. Stringent strategies need to be designed for enhancing women's access to services. All aspects of access — physical and social — need to be considered. Barriers like time, distance, costs, lack of knowledge and information, providers' and women's attitudes, and socio-cultural customs and norms are important factors affecting the utilisation of services related to reproductive tract infections, abortions and infertility.

Linkages and Collaboration

Most issues related to women's health have multidimensional social implications. For instance, how can age at marriage be raised and at the same time the fear of parents regarding the safety of their daughters during adolescence be allayed? A linkage needs to be forged between education, rural development and women and child welfare and health departments. The policy has to clarify positions

taken by each department, identify and thrash out differences and then forge strong linkages with common objectives in order that the policy may be realised.

Work, Workplace and Women's Health

Women's health cannot be separated from women's work, particularly since most women already bear a double burden in terms of work that they have to do inside the home, and work that they have to be perform outside. The policy needs to consider and include action against hazardous occupations in which women are involved: beedi-making and working with tobacco, exposure to cooking fuel, passive smoking, etc. Occupational hazards faced by women need to be considered seriously, not just because women are vehicles for the next generation but because of their own health and quality of life.

Myths and Norms Related to Women's Health

Common beliefs about women's ability to bear pain better than men and about their higher tolerance for pain because they undergo labour pains or that pain during menstruation is common and women and girls should learn to accept it are detrimental to women seeking treatment for their problems. Another perception is that adolescent girls should be slender. This could lead to less nutrition at a critical stage of their growth. Yet another view is that a pregnant woman should not gain much weight since she will have a difficult delivery if the child weighs more. Such perceptions, myths and norms need to be studied and addressed.

Gendered Health Occupations

There is a need to foster a positive relationship between women and health care providers to improve delivery and utilisation of services. Empowering women health care providers such as auxiliary nurse midwives (ANMs) by equipping them with skills and capacity is necessary if they are to function efficiently. Gendered occupations like those of ANMs have not been getting due support, though they have been burdened with achieving national goals at the field level. The increasing burden on female care providers needs to be

rationalised and they need to be strengthened with technical skills and supportive guidance. Female health workers should be given the recognition that is their due, with adequate remuneration and career advancement policies put in place. At the same time, the role of the male health staff needs to be clarified.

Medicalisation of Women's Health

Women's health should be allowed to remain in women's hands rather than being medicalised with highly technical interventions and diagnostic and therapeutic services. Reasons for institutionalising childbirth need to be clearly understood. Which environment – the home or the hospital – is comfortable for the woman? Who benefits most and from which option? Which types of deliveries or treatments really require hospitalisation? These issues also have to be kept in view.

Women's Perspectives

Closely related to medicalisation of childbirth is the issue of what women's perspectives are regarding family planning, abortion services, RTIs, surgical interventions, health care services, maternal health and comprehensive health care. A comprehensive women's health policy should attempt to understand women's perspectives and incorporate them into the services.

Women's Health Knowledge

Women, both as primary care providers and as survivors, have amassed a vast knowledge of health, health problems and remedial measures. These should be assessed and incorporated effectively into the health care delivery system.

Nutrition and Health Linkages

It is well known that poor nutrition is the root cause of most of women's health problems. It leads to an increased incidence of illness among girl children, poor development in adolescent girls, anaemia in pregnant women, nutritional deficiencies among middle-aged women and early menopause in rural poor women. Like the

weathering hypothesis (Sen and Snow 1994), the influence of poor nutrition among girl children and adolescent girls and, finally, malnutrition during pregnancy is incremental and results in high-risk pregnancy and labour. Addressing the nutritional needs of women and girls has to be at the core of any women's health programme.

Burden of Gynaecological Illnesses

Most gynaecological illnesses among women – uterine prolapse, fistula, infections, cancers and others — are a result of reproduction and childbearing. These need to be given special attention in a comprehensive health policy for women.

Conclusion

The Andhra Pradesh Women's Health Policy was meant to facilitate empowerment and gender equality through reduction in maternal mortality, improvement in sex ratio and increasing the level of utilisation of health services. However, it did not have any clear-cut and concrete strategies for undertaking activities to achieve the stated objectives. Political will and advocacy campaigns could not be sustained either by the system or the women's groups.

Advocacy for a comprehensive Women's Health Policy can be planned and carried out in a sustained and effective manner only if strong proponents are identified. In the Indian context, these would probably mean the politicians and the media. The campaign by the women's movement in Andhra Pradesh which ultimately resulted in the formulation of a Women's Policy, the supportive stand taken by widely circulated local newspapers and the momentum built thereon, were crucial. Unfortunately, in the case of Andhra Pradesh, the political will that was behind the formulation of the Women's Policy later undermined it by giving greater priority to the population policy and, within this, to demographic goals rather than to women's health.

Notes

1. Some of these are: Government to the People in November, 1995 (Prajala

Vaddaku Palana); Self-reliance and Voluntary Work Donation in January 1997 (Shramadan and Janmabhoomi) and in January 1999 the Swarna Andhra Pradesh: Vision 2020, a perspective and statement for the overall development of the state with effective utilisation of resources, which also addresses health. Some of the goals of the 'Health First' chapter in this document are to reduce by year 2020 infant mortality and child mortality to 10 and 20 per 1000 births respectively, TFR from 2.5 to 1.5, population growth from the present 1.6 to 0.8 per cent per year, increase life expectancy to 68.1 years for men and 70.6 for women.

2. The maternal mortality ratio of 437 per 100,000 births in NFHS 1 is considered an underestimate by Jeejebhoy and Visaria (1999). According to them, 550 would be a more realistic figure.
3. The NFHS 2 has estimated mortality for the country as 540 per 100,000 births.
4. Census 2001 figures, however, show an improvement in the overall sex ratio.
5. The Andhra Pradesh State Population Policy was formulated during 1997 and is being disseminated among all sections. The policy has several implications for women's health and sets the trend in the state regarding women's health.

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*Chapter 26***The Madhya Pradesh Women's Policy**
A Status Report

Ilina Sen

Following on the heels of Maharashtra and Tamil Nadu, Madhya Pradesh was among the earliest states to adopt a Women's Policy. It was also the first state to hold elections to Panchayati Raj Institution (PRIs) with reservation for women under the 73rd Amendment. It is not surprising, therefore, that in the 1990s, Madhya Pradesh was viewed as a state with a strong gender commitment. In this context, it is worth examining in detail the strength of the state's gender commitment, particularly in terms of its Women's Policy.

Situation of Women in Madhya Pradesh

Madhya Pradesh (MP) has had a dubious record in terms of female survival in the past (the expectancy of life at birth for females in 1986-91 was 54.7 years as against the male figure of 56.2 and the national figures of 59.1 and 58.1 respectively). In 1991, MP had a sex ratio of 931 females to 1000 males in the population. The sex ratio of the state as a whole was 990 in 1901, which means that we have lost about 60 women in every 2000 population since the

beginning of the century. Region-wise, the state records a wide variation in sex ratio: the lowest figures are recorded in Bhind (816) and the highest (1012) in Rajnandgaon. Very broadly, if we draw a diagonal line across the state along the Maikal–Satpura range and the Narmada Valley, the area of low sex ratio lies to the north, while that with a higher sex ratio is to the south of the line.

The importance of women's economic independence for their overall dignity and even survival is reflected in the fact that there is a startling correlation between the sex ratio and women's work participation. While overall female work participation rate (FWPR) for the state is 932, it is considerably lower in the area north of the Satpura–Narmada divide, and much higher in the region to its south. The lowest rates are found in Bhind (4.4 per cent), Morena (14.3 per cent), Gwalior (18.9 per cent) and Guna (23.4 per cent). The highest rates are recorded in the rice-growing regions of Chhattisgarh, and in other tribal districts (Rajnandgaon – 55 per cent, Jhabua – 54.5 per cent, Bastar – 51.2 per cent and Durg – 50.8 per cent).

The regional differences in mortality and work participation are a reflection of differences in women's general position in the different regions of the state. Broadly speaking, Madhya Pradesh can be divided into six socio-cultural zones: Chambal, Malwa, Bundelkhand, Baghelkhand, Nimar and Chhattisgarh. Women's status and general visibility is lowest in the northern-most Chambal region, and highest in southeastern Chhattisgarh. The other regions are at different intermediate levels.

The infant mortality rate (IMR) in the state has been 104 as against 79 at the all India level. In view of the fact that the Civil Registration system (a statutory provision) is in poor shape, district-wise vital rates are not available and, if available, are not dependable.

At the end of the Seventh Plan, the position of health facilities in the state was as shown in Table 26.1.

In a sprawling state like MP, these facilities are far from adequate. Currently, there is one doctor for a population of 7829 as against the national average of 2393. The per capita expenditure on public health

Table 26.1
Health Facilities in the State

Facilities	Numbers
Number of beds	27,712
No. of district hospitals	42
No. of community health centres	191
No. of PHCs	1,235
No. of sub-health centers	11,910
No. of medical colleges	6
No. of district TB centers	47
No. of cancer hospitals	4

reported in the Sample Registration Survey (SRS) is Rs. 19.25 as against the national average of Rs. 32.85. A health-worker in Madhya Pradesh is required to cover an area of 33.5 sq km to take care of the needs of 5000 population as against the national average of 18.5 sq km (the load on one primary health care center (PHC) according to national norms).

Although overall literacy figures for the state have shown an improvement (44.20 in 1991 as against 34.23 in 1981), the male female literacy differential persists at more or less the same level between 1981 and 1991 (29.42 per cent points in 1981 and 29.57 per cent points in 1991). The overall female literacy rate in 1991 is 28.85 per cent, but there are fairly wide regional variations. The highest figures are recorded in Bhopal (54.17 per cent) and the lowest (11.52 per cent) in Jhabua.

The education of the girl child is another problem hindering the overall process of development. To improve this, the state may have to make certain structural changes. The questions of continuing participation and access are important. MP has fairly high school dropout rates. In 1988-89, the dropout rate for girls was 42.64 at the primary school level and 69.79 at the middle school level.

Water is major issue in the lives of women. According to the 1981 census, only 20 per cent households in the state had adequate access to safe drinking water. However, the district-wise position varies widely from 4.73 per cent in Sidhi to 68.67 per cent in Bhopal (Table 26.2).

Table 26.2
District-wise Percentage of Households with
Access to Safe Drinking Water

Percentage range	Districts
Less than 10%	Shivpuri (8.73), Tikamgarh (4.93), Sidhi (4.37), Chhatarpur (6.93), Panna (5.36), Rewa (7.98), Mandla (7.66), Balaghat (5.58), Surguja (9.19).
11-20%	Morena (15.19), Bhind (13.47), Datia (12.69), Guna (14.88), Sagar (17.48), Damoh (13.05), Satna (11.21), Shahdol (10.50), Dewas (20.48), Mandsour (19.26), Shajapur (13.89), Jhabua (10.88), West Nimar (18.27), Sehore (14.13), Rajgarh (11.75), Vidisha (17.28), Raisen (17.13), Chhindwada (16.73), Seoni (13.45), Rajandgaon (12.76), Bilaspur (20.05), Raigarh (13.47), Bastar (12.72).
21-30%	Dhar (20.66), East Nimar (27.27), Betul (24.36), Hoshangabad (26.85), Durg (29.55), Raipur (20.72).
31-40%	Ratlam (35.92), Ujjain (40.43), Narsimhapur (34.90), Jabalpur (32.85).
41-50%	Gwalior (46.69).
50% and above	Indore (67.07), Bhopal (68.67).

According to the Hunger Project data (Agnihotri 1993), out of the 71,526 inhabited villages in the state, 67,044 were identified as problem villages as far as drinking water facility was concerned. Of these problem villages, 61,647 had been provided with hand pumps in the ratio of 1:250 persons by April 1993.

The Process of Formulating a Women's Policy

The Madhya Pradesh policy for women (MPWP) was prepared and ratified in 1995, in the context of two major developments in the area of women's empowerment, one national and the other international.

The national context was provided by the 73rd Amendment to the Constitution and the consequent codification of state laws, which provided for elections to the three-tier institutions of the Panchayati Raj with 33 per cent reservation for women at each level. This development effectively brought women into politics on a scale and at levels that had never been experienced earlier. Because of the traditionally subservient position that women occupied in many parts of the state, this development did not take place without trauma. In the northern parts of the state, effective participation of women in PRIs was the hardest to achieve. In the southeastern parts, and in the Chhattisgarh region, where women traditionally play a more visible role in public life, transition to the new regime was relatively smoother, although even now it is by no means complete.

The international context to the MP women's policy was provided by the activities connected with the culmination of the International Decade for Women and the Fourth World Conference of Women at Beijing in August 1995. It was the stated intention of the Chief Minister of the state to release the MP women's policy before the Beijing conference. The document was prepared in time for it to be ratified by the State Assembly prior to the conference. However, the state's Minister for Women and Child Development who was statutorily required to sign the document before placing it for discussion in the Assembly, sat on the file until November, as the entire process of preparing the draft policy had bypassed her, and had been controlled directly by the office of the Chief Minister.

The actual preparation of the document was done by a team of senior state-level bureaucrats with the help of an NGO consultant. The team studied the directives and policies of the different government departments, and recommended changes in each for inclusion in the

document. The two existing Women's Policy documents at that time, i.e., Maharashtra and Tamil Nadu, were also studied in some detail.

Through advertisements in major newspapers and letters addressed to NGOs and women's groups, the government invited suggestions on the proposed policy from the people of the state. Over 200 letters with suggestions were received in response. After the policy document was finalised, some NGOs expressed dissatisfaction that they had not been included in the consultative process to finalise the document. The state government dismissed this, pointing out that the NGOs had been invited to give their suggestions in writing. Once the document was prepared, it was circulated among a select group of women activists and subject specialists for comments; it was also presented to a large convention of women PRI members for comments and suggestions.

The Document

The actual document reflected the government's commitment to ensure equality for women in all walks of life, and to improve their condition in the political, economic, social and cultural spheres. The broad objectives were stated to be the evolution of programmes and strategies for women's empowerment and ensuring their full and equal participation in all spheres of life, including the active promotion of an ideology of women's equality, and the provision of positive discrimination, where necessary, to fulfill these goals.

The goals of the policy were comprehensive and included protection of female life, prevention of atrocities on women, and ensuring their visibility in all walks of life. A 20-point strategy was formulated and included the revamping of data collection systems to ensure women's visibility, active support to women in their role as economic producers, protection of the girl child, recognition to women-headed households, upgrading women's technical and managerial skills, and the recognition of women as major stakeholders in the development of common property resources.

The document included specific sections on the political, economic, physical and social empowerment of women, and these are worth considering in somewhat greater detail. The section on political empowerment is built around the achievement of the state government in holding elections to PRIs with reservation for women, and seeks to remove impediments to women's effective participation in PRIs through training and awareness building programmes.

The section on economic empowerment begins with the recognition that women will never be strong unless the material basis of their life and livelihood is strengthened. In the sub-section on women in agriculture, the government agrees to recognise women as farmers in their own right, and to reorient the extension programme to cater to the needs of women farmers. In the sub-section on agriculture and allied sector marketing bodies and supportive organizations, the government asserts its commitment to increase women's membership to 50 per cent of the village common lands in the joint ownership of all adult women of the village for suitable developmental activity. The document also proposes to streamline credit flow to women, and to include women in managerial positions in forest cooperatives and *tendu* leaf collection centres.

Other highlights of the section on economic empowerment are the proposals to halt female retrenchment from industry, particularly in the context of globalisation, and provide technical training opportunities for women to facilitate their integration into industry. The policy includes specific programmes to provide social security to women who have to leave the state as migrant workers.

The section on physical and social empowerment includes major recommendations in the areas of health, education, drinking water, and the girl child. In the context of health, the main focus is on strengthening vertical programmes like Integrated Child Development Scheme (ICDS), childhood survival and safe motherhood, to improve women's nutritional status and better address their reproductive health needs. Education for the girl child is declared a priority area, special efforts are promised for women

victims of violence, safe accommodation for women in service in remote parts of the state is declared a priority area, and alcoholism is recognised as a major contributor to the violence that women face in domestic and public life. The policy promises that if over 50 per cent of the women in a village or urban neighborhood want a liquor outlet removed, the government would be committed to removing the outlet within a period of 14 days.

Finally, and to end the impressive list of promises rather paradoxically, no additional financial allocation is made for implementing the MPWP, but the intention is expressed that with better management of existing resources, it will be possible to implement the main provisions of the policy.

Implementation

Six years after its formulation, it would be interesting to take stock of the extent to which the provisions of the MPWP have been put into practice. A 1999-2000 departmental document sums up the current status of implementation.

According to the document, the state government seems to have demonstrated its commitment to the MPWP by extending land rights to women. As per a government order passed in 1996, the land records of the state are to be amended to include the names of wives of men who may have been hitherto registered as single owners. Older land records are therefore to be updated in this respect. Girls are given full inheritance rights to land and other property.

The government has also effected a 30 per cent reservation for women in all government jobs, and enforced a 10-year relaxation in age requirement as a form of positive discrimination. Mandatory women's membership of cooperative and marketing bodies has been extended to 50 per cent.

Among other measures, a pension of Rs. 150 per month has been announced for destitute widows, and data collection systems have been instructed to collect data on women's work separately from

that of men. Women's cooperative banks have been given priority in document processing, an expanded ICDS programme has been launched with the support of the United Nations Children's Fund (UNICEF), women have been given priority in the drinking water committees of panchayats, and they are also being trained in hand pump maintenance. However, it must be noted here that the 'implementation' here refers only to government decision, not to any actual reality on the ground. The format of the status report reads: Recommendation – Government Decision – Execution of Decision, indicating that the polemics of governance by the state structure can really distort the picture of what is happening on the ground to the women of Madhya Pradesh.

Post-1997, a major achievement appears to be the constitution of a State Women's Commission (SCW) in 1998. But since this is not a statutory body in the state, its roles and functions are yet to be clearly defined.

An Assessment

It is important to assess the Madhya Pradesh Women's Policy from the point of view of whether or not things have actually improved for women in the state.

Although the MPWP is a fairly broad-based document, in actual fact not much has been done in terms of achieving the broader goals of the policy, i.e., ensuring women's full and equal participation in the social and economic life of the state. It is, of course, an open question whether this can be achieved by executive fiat at all. Such fundamental questions apart, it is evident that the alertness shown in the drafting of the document and making it as comprehensive as possible, is not reflected in the implementation of the policy. Right at the beginning, at the policy stage itself, there was the problem of additional resource allocation. Having made a comprehensive statement of intent in the draft document, the government more or less spiked it by inserting in the final paragraph the clause on no additional resource allocation.

There are some peculiarly circuitous arguments in the document on achievements of the MPWP referred to earlier, although it is the single document to date to discuss the concrete realities of a Women's Policy. For example, in the matter of political empowerment, the government claims to have demonstrated its commitment by ensuring elections with 33 per cent reservation for women in PRIs. This is of course, historically incorrect, as the PRI elections predate the drafting of the MPWP. There is again the matter of the extension of ICDS services in the state. This extension of the programme, funded by UNICEF and the World Bank, had also been negotiated prior to the drafting of the MPWP. Nothing has been done to ease the conditions of migrant women, and nothing at all to include women in the management of forests and *tendu* leaves, except to grant them token membership of joint forest management (JFM) committees. Even this had more to do with the funders' (World Bank) initiative rather than government action. The so-called achievements thus appear to be flaky except in the matter of reservation and age relaxation for jobs.

There are also areas where the promises have clearly not been kept. The MPWP bravely promises to remove particular liquor outlets if over 50 per cent women in a particular locality demand this. A recent press release by the excise department reveals that only one outlet has been so removed since the policy came into effect. A common ploy when women agitate for the removal of an outlet is not to close it down but simply to shift it to an adjoining neighbourhood. Frequent *dharnas* by women of the Raipur region for the removal and banning of liquor outlets are a familiar sight. However, their demands have obviously fallen on deaf ears.

The 2001 census has shown that the sex ratio in the northern districts of Madhya Pradesh has fallen even further. State government and police records show that crimes against women are on the increase, that women continue to suffer from the ills of globalisation, that safe residences for working women and the supportive structures for vulnerable women are yet to come up, and that prostitution continues unabated.

One is therefore forced to conclude that while the adoption of the policy itself was an act of political will, requiring courage and commitment, structural limitations in the administrative system, as well as a failure to inculcate the same political will at different levels of policy implementation, has meant that the implementation of the provisions in the policy has not been optimal. The MPWP is an example of a document that, while sounding progressive, remains essentially empty. While the text in some parts reads like a feminist document, the lives of the majority of women in the state continue to be governed by patriarchal oppression. In vast areas of Madhya Pradesh, the social bases of patriarchy are strong. On 1 November 2000, the Chhattisgarh region of Madhya Pradesh was constituted into a separate and new state. Since this was one region in the state where women enjoyed a relatively better status, the loss of this region is a matter of concern for the residual state. Unless patriarchal norms and values are attacked at the level of culture and civil society, change by executive fiat can only achieve this much and no more.

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Part 7

Other Issues

Affecting Women's
Health



Part I

1840

1841

1842

Chapter 27

Economic Reforms and Women's Health Some Concerns

Kumud Sharma

Health in its broad sense is not only a medical concern, but also a state of physical and social well-being and an important dimension of the development process. It is linked to the economy, education, environment and cultural practices, etc. of a society. There are a number of intersecting concerns between gender, poverty and economic reforms whose priority needs to change in the country's plans and allocation of resources. The general tendency is to subsume gender concerns within larger concerns, such as poverty, unemployment, access to education, and health, without adequately analysing the gender differentials in access to health services and infrastructure and outreach programmes. Indced, dimensions of gender-based discrimination and intra-household inequalities and power relations, which constrain women's ability to deal with change processes, need deeper understanding.

Impact of Globalisation

The process of globalisation, liberalisation and economic

restructuring has weakened the position of women in the public sector and their bargaining power in the labour market, reinforcing casualisation of women's labour. These developments have implications both for income and expenditure patterns within the household, and for women's entitlements. Health activists have reported illness as one of the significant reasons for indebtedness among poorer households. Increasing pressure on women's time and energy, and the virtual absence of support services, adversely affect women's health. In addition, data on qualitative and quantitative aspects of health services show highly uneven development in different regions of the country. Poor quality of public health care is a major barrier to women's access to appropriate health services and is associated with high maternal deaths.

A large number of countries have initiated economic reforms since the 1980s. In the debate on economic reforms and structural adjustment programmes, concerns for social costs of adjustment were projected in the mid-1980s. Since then, increasing attention has been given to distributional and equity issues.

The negative impact of adjustment measures in a majority of countries was recorded in the United Nations Children Fund's (UNICEF) Report called *Invisible Adjustment* (1988) and a now well-known document entitled *Adjustment with a Human Face* (Cornia et al., 1987). The Commonwealth Secretariat Report on *Engendering Adjustment for the 1990s* (Chinery-Hesse, 1989) and other case studies from different countries reported empirical evidence of the hidden costs of economic reforms and Structural Adjustment Programmes (SAPs), particularly for the socially and economically vulnerable sections of populations. Economic reforms have exacerbated unequal gender relations, which influence not only household income distribution, but also education of women and their access to primary health care and family planning services.

The economic downturn in India in the 1990s is reflected in:

- The reduced expenditure on public provision for health, education and social services.

- Deterioration of rupee value.
- Slowing down of growth of industrial production.
- The reduction in annual average growth rate from 7.85 in 1980-81 to 5.95 in 1997-98.
- Shrinkage of food availability to poor families.
- Declining real incomes of the poor.¹

During the reform period, expenditure on health as a percentage of GDP has come down from 4.34 per cent in 1990-91 to 3.96 in 1993-94. The per capita availability of food grains (pulses) declined from 41.6 to 36.7 in 1996-97, while that of cereals has only marginally gone up from 468.5 to 480.8 during the same period.² The Public Distribution System has not been able to respond adequately to the needs of poorer households.³

The politics of fiscal crisis, restructuring and austerity measures always obscure equity concerns. Economic reforms are gender biased as they ignore the unpaid work of women. Poor women are more vulnerable to health risks, inflation and uncertainties, which SAPs tend to increase. The changes taking place in the policies, structure and management of health systems have far-reaching implications for women, both as consumers and providers of health care.

Suggested Reforms

The World Bank's World Development Report (1993) proposes a number of changes in the health policies and content of health services, including (a) greater role of PHCs in the prevention of communicable diseases and family welfare rather than merely providers of health services; (b) active role for private sector in curative care; (c) harnessing more resources for public hospitals through user fees (studies in some African countries which have introduced user fees in public hospitals, however, indicate a slight decline in women availing of these facilities); (d) encouraging NGO initiatives in the health sector.

The declining role of PHCs and privatisation will widen the gender gap and affect health, nutrition and infant and child survival, particularly of the girl child. The role of NGOs and women's groups as providers of low-cost services cannot be a substitute for far-reaching reforms needed in the health service sector.

The Country Report prepared by the Government of India for the Fourth UN Conference on Women in 1995 acknowledged that, 'Overall, the economic pressures may compel households to resort to difficult survival strategies... the anticipated reduction in services implies that women may also have to allocate more time to activities that were previously at least partially provided by the States' (Government of India, 1994)

The efforts made to address the multidimensional problems relating to women's health have proved to be highly inadequate. The marginalisation of women and girls, lack of freedom to make their own reproductive choices, rising violence, and sex determination and female foeticide, all have a negative impact on the physical, mental and social health of girls and women.

During the last three decades, the target-oriented and aggressive approach to population concerns has not shown the desired results despite heavy investments made at the cost of primary health care. An area of distinct concern is the widespread practice of female foeticide. The 2001 Census figures have only served to underscore the plight of the girl child in India. The increasing evidence of the use of sex selection tests and foeticide has forced the Supreme Court to express 'grave concern'; even the 'Akal Takht' has declared that anyone from Sikh community practicing female foeticide or infanticide as an 'outcast'. The female deficit in the 0-6 years age group and the drop in child sex ratio by 18 points between the 1991 and 2001 censuses, place a big question mark on the rights and future of the girl child. The decline in child sex ratio is much sharper in Punjab, Haryana, Himachal Pradesh, Gujarat, Uttaranchal and Maharashtra (Census of India 2001). Social scientists believe that this is due to man-made interference in the survival pattern of girls.

An important part of health care priorities will therefore be strengthening more decentralised and participatory health care programmes. Clearly, the regional disparities in patterns of mortality, morbidity, fertility and overall health status of women are intricately linked to the social and economic development of the region. The complex matrix of the state, development and democracy influences the functioning of institutions and values and ideologies. A long and hard look at national health agenda is therefore necessary if issues of gender equity are to be addressed with any kind of clarity.

The discourse on gender, health and economic reforms in India covers several dimensions:

1. Shifts in policy directions and the principles of competition and privatisation now permeating social sectors have pushed India's commitment to the goal of Health for All by the year 2000, by providing a cost-effective and efficient primary health care system, on to the backburner.

Health services, which already have an urban, elite and male bias, are becoming more capital-intensive and curative rather than preventive. In sharp contrast to the well-equipped and highly profit-oriented urban, private hospitals and clinics, the grossly neglected PHCs tell a sad story. The highly trained medical professionals are all concentrated in urban centres while rural practitioners are largely untrained.

2. Within these basic inequalities in terms of access to quality care and services and the problem of overall deprivation and discrimination that poor and vulnerable sections face, poor women and children suffer more due to declining incomes along with increasing work burden due to survival strategies.
3. Rising prices, reduction in food subsidies, transformations taking place in terms of livelihood options and opportunities (in agriculture, fisheries, forestry, dairying and weaving), and degradation or decline in rural water and energy systems, have transformed women from the position of primary producers to that of marginal workers, labouring under extremely harsh

conditions in the expanding informal sector (the majority of women are in the rural and urban informal sector).

4. The rising prices of drugs and the unholy alliance between pharmaceutical industries and medical practitioners, the rise of the corporate sector and the expansion of private nursing homes for elites, have taken medical expertise and services beyond the reach of the common people. The notion of an integrated, cost-effective and inter-sectoral basic health care system has receded into the background. The emergence of a new medical entrepreneurial class, driven only by profit, raises a host of issues related to privatisation of health services.

The liberalised import of drugs and medical technology has also meant the pushing of harmful drugs and technologies. Lack of effective regulatory mechanisms at the national and regional levels and failure to put in place measures for market surveillance of harmful drugs and contraceptive methods have resulted in their promotion even as they are being researched for short and long-term effects. The experiments with unsuspecting women of the use of quinacrine pellets for sterilisation, and the public interest litigation against the doctor concerned, tell a horrendous tale of greed and unethical medical practices.

5. With 96 per cent of sterilisations comprising tubectomies⁴, women are still the targets of the now target-free family planning programmes. Our health infrastructure remains gender insensitive. The women still lack the power to make their own choices. Reproductive health problems, denial and neglect of the girl child, the increasing practice of sex determination and female foeticide, and violence and abuse of women, are all reflected in gender-based mortality and morbidity patterns, though not enough data is available on morbidity patterns among women. Despite the emphasis on Reproductive Child Health (RCH), the family planning programmes are vertically designed, without women's involvement and participation through decentralised planning. The critics of RCH claim that the

And except for the immunisation aspect, the child health dimension is totally missing.

6. Directly linked to health issues are population policy, public health infrastructure, social development policies and policies relating to water supply and sanitation, education, poverty eradication, food and nutrition.
7. Women's health problems are also related to our patriarchal culture and consequent gender inequalities that affect their health and well-being. The specific needs of women and children require to be appropriately contextualised in our health policy and other broad issues related to health, including economic policies.

Key Areas for Action/Concern

- i. Issues of livelihood options and food and nutrition security.
- ii. Housing, drinking water and sanitation.
- iii. Public health, infrastructure and health services.
- iv. Enunciation of a Medical Education and Population Policy; and training and education of different categories of professional and para-professional workers recommended by the Draft National Health Policy, 2001. Increasing the role of decentralised planning and provision of financial resources need to be underscored. Panchayats have yet to assume a role in decentralised health planning and monitoring.
- v. Effectiveness of women's groups in the delivery of low-cost services, targeted social programmes in community health initiatives and their impact on policy and planning process.
- vi. HIV/AIDS issues and current debates and methodologies for addressing the problem adopted by different agencies and voluntary action groups

The multi-dimensional nature of health issues cannot be addressed by selective interventions in some areas while neglecting the

development of a comprehensive public health care system. Nor can we refuse to acknowledge the inequalities rooted in our economic, political and socio-economic systems. The development of a comprehensive public health care system demands that we recognise that all these factors are interrelated and need to be dealt with through a multi-pronged approach. No piecemeal prescription will do.

Notes

- 1 *Alternative Economic Survey*, 1997-98.
- 2 Department of Statistics, Ministry of Planning and Programme Implementation.
- 3 The Approach Paper to the Tenth Plan acknowledges that the Targeted Public Distribution System (TPDS) has not worked well, though allocations to the poorer states have been more than doubled. This the Approach Paper attributes to the poor take off by the states and even poorer lifting by the states. The Paper also states that laws and controls have repressed private food grain marketing, undercutting its potential contribution to long-term food security. The Paper speaks of significant cutting in subsidies, deregulation of markets and a greater role for the private sector.
- 4 The NFHS 2 data shows that 48 percent women are using a contraceptive method compared to 41 percent in NFHS 1. Female sterilization continues to be the most popular method. Infact NFHS 2 shows an increase in the number of female sterilizations from 27 percent (in NFHS 1) to 34 percent and a decrease in male sterilization from 4 percent in NFHS 1 to 2 percent in NFHS 2.

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Chapter 28

Medicines and Health Care Women's Perspective

S. Srinivasan and Mira Shiva

Expenditure on drugs (or medicines) forms a significant part of the costs of curative care. About Rs. 16,000 crores of formulations were sold in India during 2001.¹ Although India has one of the best-developed drug industries in the third world and has promoted self-reliance in technology as well as reduced drug prices, the drug scenario in India is nevertheless characterised by several anomalies:²

- 1) Drug production does not reflect the disease pattern and health priorities of the country.
- 2) More than 80,000 formulations are produced in India. There are too many brand names of the same drug. Drugs are sold under numerous brand names even though all through medical college and usage in international and national medical journals they are referred to by their generic names and not brand names.
- 3) At least 50 per cent of these formulations are irrational. Some are even therapeutically useless, unscientific and hazardous. Irrational combinations rule the roost. The market is flooded with numerous potency drugs, aphrodisiacs, antibiotic

combinations, multi-ingredient analgesic combinations, digestive enzymes, cough syrups, and tonics and vitamins of little or doubtful therapeutic value. Ironically, many of these irrational drugs are amongst the top selling drugs. Vitamins and tonics, and other unnecessary and often inappropriate, ineffective and costly nutritional supplements, dominate in terms of sales.

- 4) Drugs banned in several Western countries, and otherwise considered unscientific and/or hazardous, continue to be produced in India.
- 5) Prescriptions are influenced by aggressive promotion of drug companies. As a result, the patient often does not get the most scientific prescription.
- 6) This is compounded by inaccurate diagnosis, lack of up-to-date knowledge, unethical practices like receiving commissions for prescribing certain drugs and sponsorship by drug companies of individual doctor's expenses as well as of medical conferences, etc.
- 7) Companies often fail to provide consumers with unbiased information about the drugs they sell. The labels on drug packages frequently omit to mention the mandatory warnings and cautions. Similarly, drugs not recommended for the elderly, for children, for people with liver or kidney impairment do not carry appropriate warnings. Ironically, when these warnings *are* present, the size of the print used to describe the 'contraindications', 'side-effects' or even 'the ingredients' is so small that they can hardly be seen except with a magnifying glass. Only the brand name is well displayed. (see Box 28.1 on Guidelines for Rational Drug Usage).
- 8) Although in 1996, the Health Ministry came up with a list of essential drugs, the Chemicals and Fertilisers Ministry, which is the nodal ministry for making policies relating to drugs, has not included any clause in the current drug policy to ensure that a certain percentage of all drug production is used for the production of essential drugs.

- 9) Poor infrastructure for quality control, weak-kneed and poorly staffed regulatory administration and overpricing of several drugs are the rule rather than the exception. The Drug Technical Advisory Board (DTAB), the body whose duty is to opine on the rationality of drugs in India, does not meet as often as it should to advise the government on rationalising the drugs in the market.³

Box 28.1

Guidelines for Rational Use of Drugs

- Prescribing a drug only when genuinely indicated
- Choosing drugs which are effective
- Using single ingredient drugs
- Using drugs indicated for specific conditions
- Choosing drugs which are relatively safe
- Choosing cheaper alternatives

Steps to rationalise the use of drugs in the market:

- Elimination of new drugs which are expensive and not necessary because other drugs with proven efficacy already exist in the market
- Elimination of useless, hazardous and harmful drugs which have irrational combinations
- Use of essential drugs list
- Marketing of drugs by their generic name

Source: *A Lay Person's Guide to Medicine. What is behind them and how to use them.* LOCOST, Baroda, 2000

In addition, the public health system in India is in a state of high disrepair. Privatising public goods and services has only made matters worse. Public hospitals and public health programmes, except in a few states, are underfunded and poorly managed. The budgetary allocation for drug purchase is even less adequately funded, with the result that drugs are regularly 'out-of-stock'. Poor people are therefore forced to purchase them from the market. Eventually, a significant proportion of them drift to private practitioners on whose rationality there is little control: a vicious circle of poverty, ill health, poor planning and poorer regulation thus sets in.

India's drug policy, including the latest 2002 version, does not view

drugs as important tools for ensuring the health of the people. Instead, it continues to focus on production and making things easier for drug companies. The number of drugs under price control has been reduced from 347 in 1979 to less than 37 in 2002. Without any controls on production of non-essential drugs, the situation for ordinary people is bound to worsen (see Box 28.2).

The process of economic globalisation, which has resulted in increasing marginalisation of the poor, loss of livelihoods and increasing food, health and economic insecurity, has also further increased the disease burden. The effect on the poor and those who otherwise cannot afford to spend can well be imagined. After dowry, medical care is the second major cause of rural indebtedness in India.⁴

Medicines and Women's Health

All this affects women as much as the general populace – in fact, in some ways, even more. Women's health care continues to be a neglected area. Except during pregnancy or for contraception, women in India hardly access the health care system. Besides the 'culture of silence' regarding health problems and lack of autonomy in decisions about their own health, family funds allocated to clinic visits and medicines are limited. It is not surprising then that women themselves tend to neglect their health, according it least priority. In families, there is often gender discrimination as to who gets health care as a priority.

Drugs affect women in special ways – particularly their reproductive system during pregnancy and lactation. They also affect the foetus in many known and unknown ways (see Annexure 28.1 on Drugs during Pregnancy and Lactation). Since they pass through breast milk, they can affect children as well. The effects of some drugs on women and their children or their children's progeny are latent and only become visible after a few years. Even though it is acknowledged that women metabolise drugs differently than men, evidence shows that drug safety data are analysed by gender only in 54 per cent of the cases and efficacy analysed by gender only in 43 per cent of the

cases⁵ (see Box 28.3 on Women and Men Respond Differently to Pharmaceuticals).

Box 28.2

Doing Away with Price Control

In the new Pharmaceutical Policy 2001 (made public in 2002) of the Government of India, a further decrease in the drugs under price control is envisaged. Under the new 'liberal' criteria for selection of bulk drugs under price control, only about 37 (accounting for about 20 per cent of the market) would be under price control, as compared with the 74 (40 per cent) under price control today and 343 drugs under price control in 1985. In addition, the Maximum Allowable Post-manufacturing Expense (MAPE) would be 100 per cent for indigenously manufactured drugs. Currently, only category II and III drugs are allowed 100 per cent MAPE.

For imported formulations, the selling price could be up to 150 per cent of the landed costs. The present provision, as per the Third Schedule of the Drug Price Control Order 1995, of limiting the profitability of drug companies would be done away with. There would be some exemptions even for the limited number of 37 bulk drugs to be under price control. Thus overall, the drug companies have been given a free hand to jack up prices.

We have argued for price control on drugs for two valid reasons:

1. Drugs are life saving and therefore should be considered as an essential commodity.
2. The consumer has no choice but to buy the medicines the doctor prescribes. Hence consumer resistance is very low in purchase of medicines.

No amount of so-called liberalisation can nullify this rationale. The need for control of drug prices thus continues. Controlling drug prices is complicated largely because of the plethora of thousands of irrational fixed dose combinations being marketed. If these are weeded out, price control will be far less difficult.

Even within the existing pattern of drug production, there is no case for giving the drug industry further concessions by reducing the number of drugs to be price controlled. We should oppose further decontrol of drug prices by concretely exposing the irrational nature of the new measures. The new drug policy titled 'Pharmaceutical Policy 2001' is pro-industry, anti-people and devoid of any medico-social rationality; it should be opposed in whatever way possible.

Box 28.3**Women and Men Respond Differently to Pharmaceuticals**

- A much higher percentage of women than men develop the life-threatening ventricular arrhythmia torsades de pointes after taking a variety of drugs, such as antihistamines, antibiotics, anti-malaria drugs, cholesterol lowering drugs and anti-arrhythmia drugs (Ebert et al., *Journal of Women's Health* 1998;7(5):547-557; Reinoehl et al., *American Heart Journal* 1996;131(6):1184-1191; Makkar et al., *Journal of the American Medical Association*, 1993; 270(21):2590-2597).
- A liver enzyme, CYP3A4, is responsible for metabolising more than 50 per cent of pharmaceutical drugs. This enzyme is more active in women than men, which can lead to sex differences in effectiveness and/or adverse reactions (Tanaka, *Journal of Clinical Pharmacy and Therapeutics* 1999;24(5):339-346; Geiter and Gundert-Remy, *European Journal of Drug Metabolism and Pharmacokinetics* 1996;21(2):123-128; Harris et al., *Drugs* 1995;50(2)222-239).
- The anesthetics atracurium and vecuronium affect women and men differently. Women are much more sensitive to the neuromuscular blocking activity of both drugs (Xue et al., *Journal of Clinical Anesthesia* 1999;11(5):397-405; Xue et al., *Anesthesia and Analgesia* 1998; 86(6):1322-1327; Xue et al., *British Journal of Anaesthesia* 1998; 80(6):720-724).
- Women wake up from anesthesia (combination of propofol, alfentanil and nitrous oxide) faster than men – an average of seven minutes for women versus 11 minutes for men (Gan et al., *Anesthesiology* 1999; 90(5),1283-1287).
- Diazepam, a muscle relaxant which is often used to treat epilepsy, impairs the psychomotor skills (control of voluntary movements) of women more than men (Palva, *Medical Biology* 1985;63(2):92-95).
- Certain types of pain killers, called kappa opiates, are more effective in providing post-operative pain relief in women than in men receiving the same treatment (Gear et al., *Pain* 1999;83(2):339-45; Gear et al., *Nature Medicine* 1996;2(11):1248-50; Gear et al., *Neuroscience Letters* 1996;205(3):207-209).
- When compared with Placebo, Ibuprofen is less effective at providing analgesic relief for women than for men during experimentally induced pain situations (Walker and Carmody, *Anesthesia and Analgesia* 1998;86(6):1257-1262).
- Women are 48 per cent more likely than men to use any abusable prescription drug, possibly because women are more likely to have a regular doctor than men (Simoni-Wastila, *Journal of Women's Health and Gender-Based Medicine* 2000;9(3):289-297).

Secondly, women are the main targets of provider-controlled population control: injectable contraceptives, oral contraceptive pills, hormone drugs, fertility regulators, IUDs, etc. In addition, not much is known about the effects of post-reproductive drugs – used for menopause, menstrual regulation and hormone replacement – on the metabolism of women. Only 12 per cent of 53 drugs approved in recent years in the USA had special studies done look at women's hormonal interactions with drugs or interactions with oral contraceptives.⁶

This should be viewed in conjunction with the tendency to medicalise pregnancy even when it is normal. Caesarians and hysterectomies are becoming increasingly common, as are unnecessary drug interventions. Again, AIDS is an unknown territory and its treatment and clinical research needs far greater gender focus than they currently receive (see Box 28.4 on *Towards Ethical Research for Women Living with AIDS*).

Because of this differential impact, women have not been included as subjects in drug studies. Instead of being used as an excuse for not doing gender-sensitive research, this very fact should provide a strong justification for a special research focus on them (see Box 28.5 on *Women and Clinical Trials*).

Sometimes drugs are wrongly advertised: Tamoxifen in the USA is a case in point. It had been advertised to imply that the drug prevents breast cancer; what it actually does is to suppress the recurrence of breast cancer in cases of early localised disease, that is, prevent breast cancer from spreading if there is early detection.

A major health problem among women and girls in India is iron deficiency anaemia. Repeated childbirth and menstrual blood loss can worsen the anaemia, as can the presence of hookworms, etc. Intake of iron-rich foods, such as food cooked in iron vessels, green leafy vegetables, fenugreek and drumsticks, as well as the intake of Iron and Folic Acid tablets (Ferrous Sulfate with Folic Acid), help in the prevention of anaemia. Folic Acid facilitates the absorption of iron in severe iron deficiency anaemia, which is why women are

Box 28.4**Toward Ethical Research for Women Living with AIDS**

A national conference on Women and HIV held at Pasadena, USA in May 1997 demanded that:

- The US FDA must require the inclusion of women in all phases of clinical research so that meaningful analysis can be done.
- The pharmacokinetics of any drug to be used by women must be assessed in women, and dosing and dose intervals determined accordingly. Without this information, no Phase II studies should be approved.
- Animal fetal toxicity and reproductive studies should be completed before an IND (Innovative New Drug) is accepted for Phase I trials. An information bank should exist describing any and all such studies and their findings. If such studies demonstrate fetal toxicity or reproductive genetic problems, women and men should be informed and should be allowed to participate if they wish.
- Pharmaceutical companies with approved anti-HIV and opportunistic infection drugs must complete Phase I studies in women and remaining animal fetal toxicity studies within one year.
- New drugs must not be approved unless sponsors present meaningful analyses — including dosing information — by gender. Statistical analyses for NDAs (New Drug Application) cannot be presented for only one gender.
- All previously approved, as well as new anti-HIV treatments and treatments for opportunistic infections must be labeled to indicate whether or not they have been tested in women.
- Women living with HIV/AIDS should be represented in all review committees for INDs, NDAs and accelerated approvals.

given both during pregnancy. But the way the drug policy is formulated in India, simple Iron Folic Acid tablets to treat anemia are not available in the retail market, which is flooded with costly and irrational Iron tonics. For example, the price of Iron Folic Acid tablets sold by LOCOST, a public charitable trust that manufactures drugs, is Rs 6.50 per 100 whereas Hepasule capsules produced by Biological Evans cost Rs. 7.40 per 10 capsules; Iberol 200 ml (10 ml of which are required to be taken twice daily according to the instructions on the packaging) is priced at Rs. 63.50 (prices as per

Box 28.5

Women and Clinical Trials

'Historically, health researchers have used male subjects to determine the safety and efficacy of drugs and treatments. Reasons given for the exclusion of women have included difficulty in recruiting and retaining women in clinical trials; concern about the potentially confounding effects of a woman's hormonal changes on the treatment; the desire to protect a potential foetus (regardless of whether a woman intends to conceive); and fear of liability issues if a foetus is harmfully exposed. As a result of these last two reasons, women of childbearing age were systematically excluded from clinical trials until very recently.

'Unfortunately, if a drug is not tested on women, there is no way to know if it is safe or effective for women. If clinical trials do not include women, potential damage to a foetus or the effects of hormone changes on the drug's effectiveness will only be discovered after the drug has been approved and is on the market. The reasons that are given for excluding women from clinical trials are the very reasons why women must be included. Additionally, the discovery of differences between male and female responses to disease and treatments has implications for both genders in clinical practice, disease prevention and medical education. Studying women could improve treatment for men and women.

'There have been several important milestones in the fight to mandate the inclusion of women in clinical trials:

1986: The National Institutes of Health (NIH) adopted a policy requiring the inclusion of women in clinical trials.

1990: A General Accounting Office report revealed that women were still being excluded. The Physician's Health or "aspirin" study, designed to examine the impact of taking aspirin on cardiovascular disease, was one of many large studies revealed to be excluding women.

1993: The NIH Revitalisation Act of 1993 mandated the development of guidelines on the inclusion of women and minorities in clinical trials.

1993: The Food and Drug Administration rescinded earlier guidelines recommending restrictions on the participation of women with child-bearing potential and left the determination of risks and benefits of their inclusion to patients, investigators, and Institutional Review Boards.' Source: www.womens-health.org

However, the question remains: is it ethical to do clinical trials on pregnant women's foetuses just to study the effects of particular treatment regimes? What will happen non-literate or otherwise uninformed pregnant women

in India if they are subjected to drug trials without being told of the consequences even though 'informed consent' may be obtained on paper? As pointed out later on in the chapter, this is worrisome, especially as India has become a favoured centre for clinical trials.

MIMS (Monthly Index of Medical Specialties) Most of these near-equivalents (that is, they contain iron, not always in the correct dose with other unnecessary drugs or minerals) contain other ingredients that are not usually necessary. Equivalent multivitamin tablets, too, would not or should not cost as much. Even though an anaemia prophylaxis programme has been in place for decades, nutritional anaemia continues to be a major problem for women and contributes to 20 per cent of maternal mortality. A recent scandal relates to preparations containing iron hydroxide polynialtose. These have been shown to be the cause of doctor-induced (iatrogenic), persistent iron deficiency anaemia despite continuous iron therapy (Mehta 2002 and Bichile 2002)! The bioavailability of iron from oral iron polynialtose in humans was found to be significantly less than ferrous sulphate.

Box 28.6

Questions to Ask

Whenever the doctor prescribes a drug, any drug, for a woman, she must try and get the doctor to answer the following questions:

- Is the drug really necessary?
- Are there non-drug alternatives?
- What are the benefits of the drug?
- What are its common, rare or serious side-effects?
- How is it likely to affect her pregnancy and lactation?
- Will it interfere with the oral or other contraceptive methods she is using or likely to use?
- Are there any safer alternatives to this drug?
- Can a small overdose, such as one extra pill, be dangerous?
- Can the prescription interfere with other medications she is taking?
- Does the drug have any serious interactions with other drugs or with a large number of other medications?

- Are there any known and/or suspected long-term effects of this drug?
- Does the drug require laboratory monitoring to ensure that she is not being harmed?
- And finally, if she experiences any side-effects, she must immediately report them to her doctor.

Box 28.7

Do the Side-Effects of AIDS Medications Differ in Men and Women?

This is an excellent question and one we are trying to learn more about. I cannot make a general statement as each drug is different. There is a study suggesting that Nevirapine is more likely to cause a rash in women compared with men. This study also suggests that the severity of the rash may be worse in women. Some experts believe that women may experience more gastrointestinal side-effects with the protease inhibitors. Some of this may be due to the fact that, in general, women weigh less than men and possibly that women are given a higher dose of medication than required. This is one reason why therapeutic drug monitoring may be useful. If we can define the levels of the drug needed, we may be able to measure that drug and adjust the dose based on the actual drug level. It is plausible that individuals experience side-effects of medications because the level of drug is too high. An example of this is Indinavir, which is associated kidney stones. There are some studies in progress that correlate the levels of Indinavir with the development of kidney stones. Hopefully, we will have some answers soon.

Unfortunately, many of the initial clinical trials included very few women, so we do not have good data on the differences between men and women pertaining to drug side-effects.

Source: Judith A.Aberg, M.D., Washington University, St.Louis, School of Medicine. Posted on 18 December 2001 at <http://www.thebody.com/Forums/AIDS/Women/Archive/WomenSideEffects/Q98672.html>

Misuse of Drugs and its Effects on Women

As has already been pointed out, most medicines have effects on pregnancy and breast milk and in some cases are known to cause congenital malformation of the unborn baby. Women, especially if not literate, are more likely to trust their doctors and use drugs that

can cause damage to the child in the womb (see Box 28.6 on Questions to Ask). Since very little drug research takes place with women in mind, it is difficult to anticipate the specific side-effects that a drug might produce in women (see Box 28.7 on Do the Side-effects of AIDS Medications Differ in Men and Women?).

Some notoriously dangerous drugs that impact adversely on women and children are: Thalidomide, Diethyl Stillbaestrol (DES), EP drugs, injectable contraceptives and implants like Norplant, Net-en, Depoprovera and Quinacrine.⁷

Thalidomide: First marketed in November 1956, Thalidomide was used for a wide range of conditions ranging from influenza, disorders of the stomach and gall bladder, mild depression, insomnia and menstrual tension. It was used in the UK as a tranquilliser and sleeping pill. Originally discovered in 1954 by a former Nazi medical officer who worked for the German company Chemie Grunenthal, Thalidomide was 'a drug in search of a disease'. It was allowed by corrupt, greedy government regulators and corporations to become the largest selling over-the-counter sedative in many European countries. By 1961, when reports of the drug's side-effects finally began being noticed, 64 million Thalidomide tablets had been sold. Some 10,000 deformed children were born as result, some of them dying in the process.⁸ Many of the surviving children are without arms or without legs. Some are limbless trunks, without either arms or legs.

Thalidomide represents a grim tale of how a drug was developed and marketed even though it lacked a sound safety history and was soon found to have horrific adverse effects, particularly on unborn children. Nevertheless, it has been approved by the US FDA for specific conditions, and is now hailed as a powerful drug to treat a number of rare and life-threatening illnesses, including multiple myeloma, brain tumour and other cancers, arthritis, lupus, Crohn's disease, multiple sclerosis, leprosy, tuberculosis and AIDS.⁹

DES: A synthetic estrogen, DES was given to at least seven million women in the USA, Canada and Western Europe between 1948 and

Box 28.8

An Uncertain Utopia

Tranquillisers and sleeping pills played a large role in the uncertain Utopia of the 1950s. One doctor testified in Congress that 'the people of this nation are being steadily educated by doctors and the drug industry to take a drug whenever they felt anxious about anything'. For many people, another testified, drugs were 'used as a panacea to solve personal problems'. In Great Britain an estimated one million people used some type of sedative daily, and about one out of eight National Health Service prescriptions was for sleeping pills. Almost all of the tranquillisers were dangerous barbiturates. Deaths from accidental and deliberate overdose were on the rise; in fact, suicide by sleeping pills was the glamorous way to check out. In 1955, the United States produced almost four billion barbiturates, or 26 pills for every man, woman and child in the country. According to Senator Hubert Humphrey, one out of every seven Americans took barbiturates.

The U.S. pharmaceutical industry was now launching over 400 new drugs every year. Prescriptions had nearly quadrupled over the past 20 years, and drug exports had increased twentyfold since World War II. There were pills for everything. Chemists had just announced a drug that could speed up suntanning ('next summer, something you swallow may turn you the colour of a life guard!'); human tests were underway on inmates at Arizona State Prison. The culture was also beginning to learn that some drugs could be very dangerous. In the United States, the 'Feds' were beginning to crack down on illegal pep pills like Dexedrine. Long-haul truckers relied on Benzedrine ('bennies' or 'co-pilots') to stay awake. There was already a booming black market in these amphetamines at truck stops around the country, and almost anyone could order large quantities of the drug through the mail.

Aldous Huxley was predicting, as he had in both *Brave New World* and *The Doors of Perception*, that even though most people still relied upon alcohol to forget Communist threats and society's woes, before long a new pill would be produced to help people unwind. Reconsidering Huxley's prediction is peculiar today, since we have progressed from 'Mother's Little Helper' — by the Rolling Stones — in the 1960s to father's little helper — Viagra — in the 1990s, and offering a whole smorgasbord of psychotropics, from Prozac to Ecstasy.

In June 1956 Huxley wrote an article in the *Sunday Times* of London, observing that Homo sapiens had been taking mind-altering drugs since prehistory — especially alcohol. 'Will the pharmacologist be able to do better than the brewers and distillers?' Huxley wondered. 'It seems reasonable to suppose it.' An executive at a British pharmaceutical firm, Distillers Company (Biochemicals) Ltd., read Huxley's article and promptly

pointed it out to the company's director, E. G. Gross, in a memo the next day. 'The ultimate target,' he wrote, 'would be the production of the ideal tranquillising agent to replace alcohol among those people who would prefer to "transform their minds" by this alternative means.' Gross replied, '... it will not be long before there are as many of these things as there are brands of whisky.'

The very same week, Chemie Grunenthal offered Distillers Company an opportunity to license Thalidomide for manufacture and distribution in the United Kingdom. From the way it was described by the German company that had invented it, this new sedative was the dream drug for the Utopian market that chemical companies around the world were aiming to conquer. It seemed to the Distillers executives like an answer to their prayers; less than a month after the Huxley article, the company brought quantities of Thalidomide back from Germany for testing.

Chemie Grunenthal was another hungry pharmaceutical company, though not yet one of the well-established corporations. Grunenthal was a family-owned business formed in 1946 that initially produced ointments, cough medicines, disinfectants and herbal medicines in an abandoned, seventeenth century copper foundry (Kupferhof), built like a fortress out of stone in the small West German village of Stolberg, near Aachen. The closest large city, Dusseldorf, has been called 'the desktop of the industrial region' for a century, and was home to the executive bureaus of coalmines, steel plants, and other heavy industry. Most of the city, apart from the Altstadt, had been heavily bombed and not yet rebuilt when Grunenthal began operations nearby in 1946. In those years, Dusseldorf was not an especially cheerful city. Even today the main boulevard, Heinrich Heine Allee, commemorates the local poet well known to doctors for 'Morphine', a poem about Heine's own terrible medical ordeal: *Gut ist der Schlaf, Der Tod ist besser, Das beste wäre nie geboren sein* (Sleep is good/Death is better/The best is never to have been born at all).

Grunenthal was a subsidiary of a large cosmetics company. Their research was unashamedly market-driven, and their initial corporate strategy was to penetrate the burgeoning antibiotic boom. Conditions in postwar Germany were appalling, and health authorities feared epidemics of tuberculosis and even cholera. So antibiotics were big business for German pharmaceutical companies.

Source: E Trent Stephens Rock Brynner. 2001. *Dark Remedy: The Impact of Thalidomide and Its Revival as a Vital Medicine*. Perseus Publishing.)

1971. Initially, no one was sure what it could be given for. It was tried in many clinical conditions but soon came to be used for

preventing miscarriage, based on the theory that habitual abortion was caused by a lack of progesterone and could be prevented by giving estrogen that would in turn stimulate the production of progesterone. It was promoted for making normal babies more normal. Clinical trials showed that DES was not only ineffective but also unsafe. The link between DES and cancer was surmised in 1971 – animal studies way back in the late 1930s and 1940s had shown that DES and estrogens could cause cancer. It also increased chances of abortion. DES daughters are more likely to get carcinogenic abnormalities, with 40 per cent of them likely to have had structural defects in the cervix, vagina, uterus and fallopian tubes. Compared to non-exposed women, DES daughters run four times more risk of miscarriage and pre-term labour. Ectopic pregnancy, a life-threatening condition, was found to be likely in 4-8 per cent of DES daughters. The complications continued with findings that showed that mothers who took DES had 1.5 times more chance of getting breast cancer, and probably increased the chances for the daughters too.

‘Diethylstilbestrol (DES), a synthetic estrogen, can cause vaginal cancer in adolescent girls whose mothers took this drug during pregnancy. These girls may later suffer from an abnormal uterine cavity, menstrual problems, a weakened (incompetent) cervix that can cause miscarriages, and an increased risk of having an ectopic pregnancy or having a baby who dies shortly before or after birth. Boys exposed to diethylstilbestrol as foetuses may have penis abnormalities.’ (www.merck.com. Home Manual).

High Dose EP Combination Drugs: Around 1982 drug activists in India found that a whole class of high dose Estrogen-Progesterone combination drugs (EP Forte, etc.) was being misused by doctors for regularising periods, testing for pregnancy and as abortifacients. These drugs, which contain the same female sex hormones as the combined oral contraceptive pill but at a higher level, were used in the 1950s to regularise missed periods since they were thought to start menstruation in women whose periods were delayed but who were not pregnant. A woman whose periods did not start after taking

EP drugs was presumed to be pregnant and hence EP drugs were also used for pregnancy testing. But because the drug could apparently bring on menstruation, EP drugs were misused to induce abortion. Although no pharmaceutical company had ever claimed that these drugs could induce abortion, there is evidence that in India they were prescribed for this purpose and were also sold over the counter for hormonal pregnancy tests. They were also prescribed for endometriosis, functional uterine haemorrhage and menorrhagea.

About 20 years later, research uncovered evidence that the EP drugs were not only unreliable as a pregnancy test but also ineffective as treatment for missed periods. In fact, research indicated that the drugs were associated with birth defects. Dr. Isabel Gal was the first to show a correlation between congenital abnormalities and hormonal pregnancy tests and warned about the need to seriously look at the use of hormones in pregnancy. For this, she lost her job and was hounded. Yet, the withdrawal of these drugs in UK and out-of-court settlements with some of the pharmaceutical companies was only possible due to her sincere efforts. She also helped by providing documents for the Public Interest Litigation and the Public Hearings on EP drugs in India. Women who used this drug for pregnancy testing and continued with their pregnancy, exposed their unborn babies to the possibility of birth defects. Cases of birth-defective EP children have been documented. Those who took the drug to induce abortion but did not abort also ran the same risk. These drugs were produced and marketed as safe products, without any warning to doctors and women about their teratogenic effect. Though many countries had banned them, and Organon, one of the major manufacturers, was not allowed to manufacture or even register the drug in its parent country (Netherlands), these drugs continued to be sold in India. After a relentless, six-year long campaign by health and consumer groups, in 1988 the Indian government banned the manufacture and sale of high combination of EP 'containing per tablet estrogen content of more than 50 micrograms and of progesterone content of more than 30 milligrams' (LOCOST 2000; VHAI 1988).

There are several other drugs that are a cause for concern. Over the

years there has been a whole slew of drugs whose teratogenic effects have come to be known: anti-cancer drugs, warfarin, anti-convulsants, inhalation anaesthetics, tobacco, alcohol, some psychotropic drugs and barbiturates, tetracyclines, chloremphenicol, some antimicrobial agents and aminoglycosides, antimalarials, antithyroid drugs, corticosteroids, some sympathomimetic drugs, narcotics like morphine, heroin and methadone, and drugs used for premature labour and induced labour (see D.M. Davies [ed.] *Textbook of Adverse Drug Reactions*, OUP, 1981 and after; also chapter on "Drug Use during Pregnancy" in Merck Home Manual at www.merck.com).

Even in Ayurveda, there are certain drugs that should never have been manufactured, let alone sold. For example, 'Select', which allegedly converts girl foetuses into boy foetuses when taken during pregnancy. The Ayurvedic drug Sura, which has a high alcohol content, is another drug that should never have been licensed for production. The Indian market is flooded with numerous aphrodisiacs whose side-effects have not been studied.

Oxytocics like Syntocinon are given to pregnant women to precipitate labour while they are indicated for women who have reached their term but whose labour pains have not started. It is being grossly misused for the convenience of health care providers. While it should be administered slowly through intravenous infusion to ensure that the contractions begin as slowly as they do during natural labour, it is administered intramuscularly. This quickens the contractions, giving the uterine muscles no time to relax adequately and thereby preventing nutrition and oxygen from reaching the unborn baby through the placenta. There have been cases not only of ruptured uterus but also of children being born with birth anoxia resulting in permanent mental retardation and cerebral palsy. In the class of pharmaceuticals that are being used only for women, next to female hormones oxytocics have been the second most misused category.

Contraceptive Drugs and Women

Apart from the efforts under the Government of India's Family Welfare Programme to increase contraceptive choices, there is also pressure from the manufacturers of contraceptives and their international lobbies, often giant international NGOs and funding agencies, to target these contraceptive 'choices' at women. Long acting and provider-controlled, the contraceptives are rarely under the control of the user women. Research in contraceptive technology continues to be targeted at women: Net En, Norplant, anti-fertility vaccine, RU486. Many of these contraceptives are known to have serious side-effects. In fact, most require proper screening of women for whom the usage of these contraceptives would be contra-indicated. In cases where pregnancy has not been excluded, long acting hormonal contraceptives are contraindicated. Some are also contraindicated for women who have an irregular menstrual cycle, jaundice, acute or chronic liver disease, hypertension, diabetes, cancer of the breast, uterus or cervix, lactating breast-feeding mothers and women taking anti-TB drugs (these are contraindications mentioned by the makers of Depo Provera). Some of the side-effects include menstrual disturbances, hormonal imbalance, circulatory and cardiovascular problems, increased risk of cancer and infertility.

Quinacrine Sterilisation

Quinacrine is an anti-malarial drug that has been used for permanent sterilisation of women. When Quinacrine pellets are inserted into the uterus, they burn and block the tissues at the mouth of the fallopian tubes. The drug has not been adequately tested and has a high failure rate as a contraceptive. Moreover, it has serious side-effects like genetic disorders, deformities in future babies in case of failure, risk of cancer, ectopic pregnancy, menstrual disorders, severe abdominal pain, headaches, backaches, pelvic infection and itching and nervous and genetic disorders.

Trials were carried out on unsuspecting women despite WHO's recommendation for stopping human trials pending further toxicology tests, since initial tests had revealed possibilities of

were conducted in violation of medical ethics – without the informed consent of the women who were recruited for them – a fact which came to light in 1986, when village women who were attending a family planning camp were injected with Net En without even being informed that they were part of a trial of an unapproved drug (Bal et al. 2001). This prompted Saheli, Chingari and several other women's groups and individuals to file a writ petition in the Supreme Court of India in 1986 asking for a stay on the Phase IV clinical trials of Net En. Though the case against Net En was still pending in court, the drug was approved by the Drugs Controller of India for import and marketing by private practitioners in 1986 and officially launched in India for 'social marketing' in 1994. The stay order has been since lifted by the Court.

Depo Provera (Depo Medroxy Progesterone Acetate)

Depo Provera is another injectable contraceptive for use by women, manufactured by the American multinational, Upjohn. This drug is not allowed for use as contraceptive in USA, but may be prescribed by a doctor after the women gives her informed consent. Yet the drug is sold in the third world for contraceptive use. It is associated with breast and endometrial cancers, osteoporosis, lowered life expectancy and lowered resistance to infections. In addition, the drug causes severe birth defects if ingested by a woman who is unaware of her pregnancy. Its effect on babies when it passes through breast milk is not well documented, but it could interfere with the babies' normal development and inhibit the transmission of immunities. Despite this knowledge, Upjohn promotes this drug for nursing mothers because it does not stop the flow of breast milk. Depo is also known to cause depression, hair loss, headaches, weight gain/loss, menstrual spotting, heavy bleeding, skin changes, nausea and loss of libido. Earlier trials in Chandigarh were stopped because of severe bleeding problems. The weight of evidence against the use of this contraceptive is 'sufficient to compel its proponents to admit to the injectable's potential for adverse outcomes, including death'.¹⁰

The difference between the package insert for the same product given

carcinogenicity. In 1992, the Indian Council of Medical Research (ICMR) prematurely terminated its trial due to high rates of failure and complications. However, in collusion with drug companies several private organisations of medical professionals continued to carry out trials with this method of sterilisation. This was done without obtaining clearance from the Drug Controller of India or informing ICMR. Quinacrine trials also highlight that there could be several other such clinical trials going on about which the concerned authorities are unaware. As the outcome of an intensive campaign against aggressive promotion of quinacrine sterilisation started by two US-based doctors and their organisation, the International Family Health Association, a public interest litigation was filed within India by, among others, academics and activists from Delhi's Jawaharlal Nehru University (JNU) and the All-India Democratic Women's Association (AIDWA) to ban the use of quinacrine for female sterilisation. In March 1998, the Drug Controller of India gave a written commitment to the Supreme Court that the use of quinacrine for female sterilisation would be banned. The Court was also assured that the government, through a gazette notification, 'prohibits the manufacture, sale or distribution' of quinacrine in pellet form. Any violation of the order would be punished 'with imprisonment for a term which shall not be less than five years, but which may extend to a term of life...and with fine which shall not be less than ten thousand rupees' (Bal et al. 2001).

Net En (Norethisterone Enanthate)

Net En is an injectable contraceptive with both short-term and long-term health effects. It is contraindicated in women with hypertension, diabetes, thromboembolic phenomenon, hepatitis and in pregnancy. Hazards include menstrual chaos, adverse impact on the hypothalamus-pituitary axis in the brain, which could lead to undesirable effects on other systems of the body and systemic disruption. Long-term risks include the possibility of cancer and risk to progeny due to *in utero* exposure. Moreover, return of fertility is not assured. In 1983 and 1984 the ICMR initiated Phase IV trials of Net En in rural and urban centres to test its acceptability. These trials

to doctors in the US and India was pointed out by women's groups who accused Upjohn of double standards. They also protested against its launch, given that the deteriorating state of public health services would make it difficult to ensure the exclusion of women for whom injectable hormonal contraceptives were contraindicated and those who already suffered side-effects and needed follow-up. Depo Provera was introduced into the Indian market without any Phase IV trial, which means that the Indian state conducted no research specific to Indian users before deciding to introduce the drug in the market. The drug dosage was originally designed for the larger, better-nourished and healthier Western women. It has not been decreased proportionately for the smaller Asian women who are now the target for this drug. Despite the Net En controversy, Depo Provera was also officially launched in 1993 for the private market with Max Pharma and for 'social marketing' in 1994 (Bal et al. 2001; Saheli 1998; Sama 2000).

Under pressure from international funding agencies, the Government of India may be keen on introducing these long-acting hormonal injectable contraceptives in the National Family Welfare Programme. However, past experience with oral contraceptives and IUDs shows that the health delivery system in India is not equipped either for screening women for contraindications or for monitoring and follow-up of these women. Moreover, the chances of uninformed or ill informed use are also high. Women may be administered the drug without their knowledge, or informed only about its conveniences and not its potential hazards, as in the case of Net En Phase IV trials where women were only told, 'Take this injection, you won't get pregnant' (Bal et al. 2001; Sama 2000; Sathyamala 2000).

Other Contraceptives

There are other contraceptives like oral pills, IUDs (intrauterine devices) and implants like Norplant, about which women need to be educated before deciding to adopt them. The most infamous of IUDs was the Dalkon Shield, of which about 2.8 million were marketed in the USA in the early 1970s. Problems, caused primarily by the tail

of the device, led to serious PID (pelvic inflammatory disease) in thousands of women and resulted in death for at least 18 women. Several lawsuits and FDA investigations later, Dalkon Shield was withdrawn, in June 1974 from the US market and from outside USA by March 1975. A trust fund was set up with more than US \$ 2,300 million to settle claims. Unfortunately, none of the Indian women using Dalkon Shield spacing as part of an USAID programme were aware of this and therefore could not file for damages. In any case, no medical records of the use of this method was available in India. Some improved versions of the IUD (the 'loop') have become the standard female barrier method advocated in India's Family Welfare programme. IUDs can cause severe problems, such as excessive vaginal bleeding and anemia, and therefore need to be used with caution. Oral contraceptive pills, too, need to be used with caution as they can cause havoc with a woman's metabolism.¹¹

Norplant

Norplant is a subdermal (under the skin) implant that can prevent pregnancy. It consists of six matchstick-sized rubber capsules that are programmed to slowly release progestin (levonorgestrel) and is implanted under the skin of a woman's upper arm via a minor surgical procedure using local anaesthesia. The implant is claimed to be effective for five years.

The use of Norplant-2 and its latest version, Norplant-R, has been opposed by women's groups and other concerned persons in India, chiefly on the grounds that it can be inserted and removed only by doctors and that it can lead to serious problems, ranging from ectopic pregnancy (pregnancy in the fallopian tube) to severe bleeding and, in some cases, foetal abnormalities.¹²

The earlier, two-rod version of Norplant (Norplant-2) had already undergone Phase III testing in India. However, the manufacturers were forced to stop producing the silastic material for the rods because of fears of its carcinogenic effect on workers who would be exposed to large quantities of the material. Attention then turned to the six-rod Norplant-R made of a different material. In 1992, ICMR

announced Phase IV trials of Norplant-R, arguing that since the progestin released by the two implants was identical, the results of Phase III trials of Norplant-2 could be applied to the six-capsule Norplant-R.

Protests from women's groups followed. They argued that Norplant-R was a different device — the drug delivery system was different — and demanded that it undergo safety tests before pre-programme introductory trials. As a result of this pressure, a Phase III trial for Norplant-R was designed. The trial depended on the 'cafeteria' approach to select volunteers: women approaching health services for contraceptive advice were asked to choose after being informed of the various methods available.

Eventually, however, bowing to public pressure, the Government of India abandoned the trials and use of Norplant-R.

Anti-Fertility Vaccines (AFVs)

AFV, an anti-HCG (human chorionic gonadotrophin) vaccine, is one of the range of immunological contraceptives that is being sought to be introduced.

The vaccine seeks to induce temporary infertility in women by turning the immune system against those components in the body, which are essential for human reproduction. The human pregnancy hormone HCG is altered, then coupled to a bacterial or viral carrier so that the immune system mistakes the natural pregnancy hormone for an infectious germ and reacts against it. The body thus does not get a signal to prepare for pregnancy and the fertilised egg is expelled.

In India, clinical trials for AFV were begun on humans well before testing its impact on animals was completed. This was in contravention of the 1978 safety guidelines laid down by WHO for conducting research on anti-fertility vaccines. Serious concerns have been voiced about its possible impact on the spread of HIV and other infectious diseases. It is also well known that women are more prone to developing auto-immune diseases. Yet researchers doing AFV research argue there is no scientific evidence to indicate whether AFV, per se, would increase or reduce the risk of HIV infection,

except that it is a non-barrier method.

Whatever the nature of the contraceptives used, it is imperative that they assure safety not only in terms of breast-feeding and the women's reproductive system, but also – and more importantly – women's fertility. None of the contraceptives, including IUDs and the oral pill, seem to assure this. Nor are they sensitive to the social and cultural disruption that prolonged menstrual chaos and excessive bleeding can cause for women.

One should recollect that injectable contraceptives did not get US FDA approval for almost 20 years, mainly because of evidence of a carcinogenic effect thrown up in WHO's multi-centre trials. An escape hatch was provided when WHO changed its directives for contraceptive research and ruled that evidence from animal studies was not fully indicative of a contraceptive's side-effects. The trials, conducted mainly in the third world, subsequently concluded that injectables were relatively safe, but the details of their results were not made public.

It is important to reassert that the findings of all research on drugs, especially if they are to be marketed, must be available in the public domain. Answers to such questions as who is doing the research, who is funding who, what are the research and treatment protocols, what are the short-term and long-term effects on women and her progeny, and what are the arrangements for monitoring adverse reactions and effects once the drugs are introduced in the market — must be the least that is available from the office of the Drug Controller of India; they should be available on the web as well.

'Social Marketing' of Contraceptives

The term 'social marketing' appears to be a misnomer. While it makes contraceptives available to NGOs and allows for their prescription by private practitioners, it does not ensure their availability in the government health care system. Social marketing, which includes over-the-counter sales, inevitably leads to ill-informed use of contraceptives without an understanding of their side-effects, or of the meaning of symptoms that may manifest upon use. In order to be

effective, social marketing requires good back-up and referral services that women can access in times of emergency and adverse symptoms. With the liberalisation of the economy, a dramatic change has taken place in the field of medical research. Social marketing of contraceptive drugs by NGOs and private practitioners, who are supported by large grants from drug companies and international funding agencies, is in any case a cause for concern since most NGOs are more or less only implementing agencies. Adding to it is the disturbing trend of replacing Phase IV clinical trials done by accredited bodies using accepted and valid methods of research by some version of 'Post-Marketing Surveillance (PMS)'.

Generally, animal and clinical trials of contraceptive drugs only test safety and efficacy in the short run; they fail to detect the long-term and rare side-effects of the drugs, which requires continued PMS over a long period of time. It is doubtful that clinical trials and PMS conducted by pharmaceutical companies would be objective, since they are more likely to be driven by profit rather than concern for public health, in this case, women's health. While no PMS on Net En has been made public since its approval for marketing, the report of the PMS conducted for Depo Provera between June 1994 and December 1997 by its manufacturer Pharmacia-Upjohn, was made public only in 2000. Though projected as a five-year study, this PMS was conducted over three years. It studied each woman user for 15 months only, while the intended duration of Depo Provera is two to three years. Fifteen months were therefore inadequate to assess long-term effects. The study also did not assess the potential side-effect of loss of bone-density and risk of osteoporosis or cancer; nor did it assess return of fertility or the effect on progeny conceived accidentally or immediately on discontinuing the use of Depo Provera. Problems such as amenorrhea, irregular bleeding, general weakness, migraines and severe abdominal cramps were considered 'non-serious' (Bal et al. 2001). Also, in the case of Depo, there is evidence to show that it is life-threatening (Sathyamala 2000) and its association with breast cancer has not been ruled out.

The entire burden of contraception and its side-effects, no matter

how serious, is borne by women, as is the outcome of conception — whether an unsafe abortion, an unwanted pregnancy and/or the birth of an illegitimate child. The irresponsible sexual behaviour of the ‘inflictor’ of pregnancy is never addressed as aggressively as the women who are targeted for the contraceptives. It is little wonder that potentially hazardous contraceptives for women are preferred to safer cheaper, easier, male contraceptive methods, including the condom and non-scalpel vasectomy. ‘Social’ marketing thus seems to be a tool for abetting such unethical promotion. Abandoning PMS or diluting it only compounds the problem.

Hormonal Replacement Therapy (HRT)

HRT is a classic case of the industry exploiting the women’s ‘market’. The leading products under the label of HRT seek to promote estrogens for use by post-menopausal women. The attempt is to portray a natural process like menopause as a disease condition that needs treatment. Menopause results in the cessation of estrogen and progesterone production. HRT seeks to correct this by making women ingest these very hormones. Studies have shown that long-term use of unopposed estrogen can lead to increased risk of endometrial cancer.¹³ While HRT may be indicated for some women for problematic post-menopausal syndrome, its aggressive promotion for all post-menopausal women is irrational and unethical.

Estrogen and breast cancer: Because growth of breast tissue is highly sensitive to estrogens, the more a woman is exposed to estrogen over her lifetime, the higher the risk for breast cancer ...

Role of estrogen metabolism: A 2000 study suggested that the likelihood of estrogen increasing breast cancer risk in pre-menopausal women is related to how it is metabolised. In some women, very powerful estrogen products, or metabolites, are generated when metabolism takes place at a site on the estrogen molecule called C-16. These metabolites appear to pose a higher risk for breast cancer. (This metabolic effect does not appear to occur in post-menopausal women.) Fortunately, the study suggests that healthy diet and exercise may be able to alter this process....

Hormone replacement therapy and breast cancer: A number of

studies have indicated an increased risk for breast cancer in post-menopausal women taking hormone replacement therapy (HRT). The longer a woman takes it, the greater the risk, with the risk increasing by 2.3 per cent each year. Oddly enough, one study suggested the risk in HRT-users is higher the thinner a woman is (stopping the drug reduces the risk so that it is normal after five years).

Reliable long-term studies now report that progestin plus estrogen pose a greater risk for breast cancer than estrogen therapy alone. One 2000 study, in fact, reported a higher risk for lobular (a rare form) rather than the more common ductal breast cancer with the combination therapy and no greater risk for any breast cancer with estrogen alone. The combination treatment increases the amount of breast tissue, which is not only a risk factor for breast cancer itself, but also makes mammograms more difficult to read.

Some studies have suggested that breast cancers in women taking hormone replacement therapy tend to be invasive but associated with a favorable outlook, although a 2000 study reported no difference in prognosis compared to women not on HRT. Whether estrogen replacement therapy increases the danger for recurrence in patients with a known history of breast cancer is unclear. Recent evidence suggests that it does not.¹⁴

However, other researchers feel that 'there is inconsistent evidence as to whether HRT will increase/decrease the risk of breast cancer.'¹⁵

Also, there is confusing evidence about whether HRT can reduce heart attacks. 'Numerous studies have been conducted on the effects of HRT on heart disease and have suggested that HRT decreases heart disease risk or heart disease risk factors such as LDL levels (bad cholesterol). However, these studies were mostly observational studies where women themselves (or their physicians) chose HRT and were followed over time. Such studies are not reliable. They were not controlled enough to offer definitive answers.'¹⁶ HRT appears to lower the risk of osteoporosis but the final word has not been said on whether it will lower bone density loss and lower the risk of fractures without increasing the risk of breast cancer.

If hormones are to be used to prevent heart disease, they will need to be prescribed for a long time, perhaps decades. By medicalising post-menopausal problems, HRT has the potential to do more harm than good.

There is also deep concern about the routine oophorectomies (surgical removal of ovaries) being done along with hysterectomies (surgical removal of uterus) in young women with bleeding problems. This results in sudden menopause (the so-called medical menopause) and subsequent creation of dependence on HRT.

Globalization, TRIPs vs. the Health-for-All Ideal

'The pharmaceutical industry is unique in that it can make exploitation appear a noble purpose.'

The growth of giant drug pharmas and their influence in WTO — especially in the very writing of the Trade Related Intellectual Property Rights (TRIPs) agreement — has taken the issue of drugs out from the realm of health and placed it primarily in the realm of trade. This situation has been made worse by the tendency of corporates to control and own knowledge in the name of intellectual property rights — knowledge that rightly belongs in the public domain or owes its origins to funding by governments (see accompanying boxes on Patenting Pharmaceuticals and Compulsory Licences). The TRIPs agreement has been drafted by the trade associations of the US, Europe and Japan, along with giant corporations like Monsanto, Dupont, Pfizer, Bayer and Merck. It is thus biased in favour of corporations rather than people in general.

The provisions of TRIPS have served to undermine some of the very processes that helped India become one of the leading countries in manufacturing drugs with some of the lowest prices in the world. Some of the changes brought in by the new patents TRIPS/WTO regime include: patents on products only, and not on processes; importation to be equal to 'working' a patent; burden of proof in case of patent violation on the alleged violator; and duration of patents to be for a minimum period of 14 years. Accompanying this is the trend to reduce the number of drugs under price control in the name of liberalisation. For India, this means the erosion of all Indian sectors — public, private and small-scale — and overpricing of a large number of essential and life saving drugs.

Compulsory Licensing (see Boxes 28.9 –28.11) is granted under Article 8 of TRIPS but it is still contested by pharma companies. The threat of Trade Sanctions by US against South Africa for wanting to produce anti-AIDS drugs under compulsory licensing, which is allowed under TRIPs, highlights that provisions for the developing countries, e.g., Compulsory Licensing and Parallel Imports, will not come easily even if permitted by the TRIPs regime.

Box 28.9

Patenting Pharmaceuticals

A WHO discussion study paper on the effects of the new intellectual property rights relating to pharmaceuticals, especially in developing countries, concludes that:

- although patent protection of pharmaceutical products will be enhanced, this will not necessarily be to the benefit of all countries;
- it is likely that local production in developing countries will increasingly be replaced by imports of finished products, i.e., trade in drugs will increasingly replace direct foreign investment and the granting of licences to local companies;
- no prospect of increase in research and development of new drugs in either developed or developing countries;
- the transitional period for entry into force of the Agreement allows countries to continue to limit the introduction of pharmaceutical patents;
- measures to be borne in mind by countries when incorporating the provisions of the Agreement into domestic legislation are:
 - * including in domestic legislation a series of compulsory licences to act as an effective deterrent to monopolistic practices and to encourage access to licences by local companies under reasonable conditions;
 - * guarantee of the import of certain products on the principle of 'international exhaustion' (e.g., if a patented product is sold in country A at a price of US \$100 and in country B the same product is sold at US\$80, this principle allows any interested party in country A to import the product from country B without the consent of the patent's owner);
 - * exclusion of certain substances from patenting;
 - * restriction of the reversal of the burden of proof to process patents for new chemical entities.

Box 28.10

Compulsory Licences

The (TRIPS) Agreement grants members the right to compulsory licences on certain grounds. These include:

Public health and nutrition or other reasons of public interest —

Article 8 (“Principles”) of the Agreement specifically recognises the right of members to ‘adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socio-economic and technological development.. ..’ Many countries, including some developed countries, provide for such compulsory licences in their legislation.

National emergency and extreme urgency —

This is specifically mentioned in Article 31 (b). It could also be considered to be covered by other general formulations such as ‘public interest’. In such cases, prior negotiations with the right holder can be avoided.

Public non-commercial use —

In this case, a government is directly interested in using the patented invention for non-commercial purposes.

Anti-competitive practices —

Compulsory licences can be granted to prevent abuse of a dominant market position.

Refusal of a voluntary licence —

The TRIPS Agreement also authorises the granting of a compulsory licence when a patent holder refuses a reasonable commercial offer, which he has been given a reasonable amount of time to consider.

Other grounds —

The Agreement does not limit the grounds for granting compulsory licences: domestic law can define the grounds for granting such licences, including those that are not mentioned in the TRIPS Agreement, which is only indicative in this respect.

The case of South Africa anti-AIDS drugs clearly shows that it is profit that guides international trade, irrespective of the lives being lost. Africa has the largest number of AIDS victims. For Africa it is clearly a public health emergency and African countries are poor. In South Africa, a democratically elected national government's decision to produce anti-retrovirals under compulsory licensing or importing cheaper generic equivalents under parallel import for their

Box 28.11**What Should be Done?**

So when we talk of renegotiating/reviewing TRIPs, what is the ideal we should agree to within the country and within WTO? It could run something like this:

- (1) India works out a drug policy that favours long-term technological self-reliance and production of only essential drugs.
- (2) The national drug policy should get preference over any WTO-imposed regulations.
- (3) Product patents should be granted only to new essential drugs that are safer, cheaper and have greater efficacy than the older products.
- (4) Product patents on all essential drugs should be limited to only 10 years in national interest. Subsequently, no patent extensions should be given for new dosages and specific new usages.
- (5) Price control should be implemented on all essential drugs, and especially on new drugs under patent. The maximum price of new drugs under patent should not exceed the cheapest international price of the drug.
- (6) Importation should not be equated with manufacturing. Manufacturing within the country should be made compulsory within three years, if necessary by using compulsory licensing.
- (7) Parallel importing should be explicitly legitimate in WTO provisions.
- (8) There should be no patents on life forms and on traditional medicinal knowledge or obvious derivatives thereof.
- (9) The burden of proof vis-à-vis the safety of the drug, chemical or pesticide should be on those introducing the drug in the country.
- (10) A pharmaceutical technology bank should be specifically set up for the third world with the explicit purpose of demystifying technology and strengthening third world pharmaceutical technology capabilities.

Source: Srinivasan, S. 2000. 'Pharmaceuticals, WTO and Seattle Round', *Economic and Political Weekly*, January 29.

people was stalled with 39 pharmaceutical companies challenging this decision in the South African Court. It was because of the bad publicity given by the AIDS activists and Rational Drug Use Campaigners and the global denunciation following the drug companies' law suit, 39 drug companies on April 19, 2001

unconditionally dropped the case they pursued for three years against the South African government. The end of the lawsuit cleared the path for the 1997 Medicines Act to go into force, allowing for importation of affordable medicines and increased use of quality generic drugs.¹⁷

In Africa the average spending on health per year per person is \$10, i.e., Rs. 500. The annual expenditure per person is \$10,000 for anti-retroviral drugs, with expenditure on generic equivalents being \$350-\$500. The reduction in prices is thanks to, among others, the Indian company Cipla, which was/is ready to give the anti-retrovirals for \$350 per annum to the governments of poorer countries where AIDS is the biggest killer. Anti-retroviral drugs, once started, must be given for life. In the absence of comprehensive health programmes, optimisation of resources, sustainable people and community-centred programmes and strategic interventions with responsible health financing and resource use, anti-retroviral drugs will remain unaffordable and unavailable to those who need them.

The Brazil case serves as another eye-opener for the world. The Brazilian government, well within its rights and well within the TRIPs framework, chose to produce anti-AIDS drugs incorporating compulsory licensing in its National Patents Act. The US government took the Brazilian government to the WTO Dispute Settlement Forum in Geneva on the charge that this action was violative of TRIPs. Following protests by people's action groups in Geneva at the World Health Assembly and elsewhere, the US government withdrew its case on 25 June 2001.¹⁸

It is very clear that the TRIPs safeguards, reiterated in the Doha Statement on Public Health, will not be easily available to third world or developing countries, at least not without a struggle. The kind of diplomatic, political and perhaps even immoral pressures that would be brought, on behalf of the drug companies by the respective governments of Western countries, on our politicians can well be imagined. With importation to be counted as working of the patent without bringing in the actual manufacturing technology, developing countries would suffer. Countries whose currencies have been

devalued as part of the Structural Adjustment Programmes would suffer much more — as they would have to spend more to get less in term of purchase of medicines as well as technologies.

But activists and people concerned must realise what has probably happened in Brazil and South Africa is a tactical withdrawal by the US government and the drug companies. Other disturbing trends continue. For instance: the closing down off the UNTNC Centre which periodically brought out the consolidated the list of drugs and chemicals whose use was restricted clearly shows that agencies and voices that question and those that will negatively affect market are being eliminated.

Growing Concerns

There are many areas where pharmaceutical companies are actively searching for new drugs. Given the track record of most drug companies, these need to be viewed with caution and concern.

India as a 'Destination' for Clinical Trials

India is becoming a favoured destination for clinical trials. The reasons for such 'popularity' seem to be: (a) large population and genetic diversity; (b) low cost; (c) legislative vacuum or infirmities (d) ignorance about the legal and ethical issues of human trials among the public and even health care professionals; and (e) craze among the developing countries to link up with Western institutions unthinkingly and at any cost.¹⁹ The fee for import of a new bulk drug or formulation is fixed at Rs 50,000, whereas the fee for import of a new fixed dose combination is fixed at Rs 15,000. The application fee for Phase I clinical trials is Rs. 50,000 while the fee for both Phase II and Phase III trials is just Rs 25,000 each. Many of these companies will in due course get 'informed consent' of illiterate poor people even as unsuspecting women will be targetted with drugs known and unknown.²⁰

Human Cloning and Embryo Research

The whole area of human cloning is fraught with possibilities of

human rights violation in general and women's health and reproductive rights in particular. For its advancement, human cloning will need, among other things, mass experimentation on women and children. Like companies pushing contraceptives, cloning advocates tend to appropriate the language of reproductive rights and freedom of choice to support their case. This is absurd and needs to be countered forcefully.

'There is an immense difference between ending an unwanted pregnancy and creating a duplicate human. Most people readily understand this, and can support abortion rights while opposing human cloning.... We also call for a moratorium of five years on the use of cloning to create human embryos for research purposes. At the same time we support research that would help to determine whether stem cells have therapeutic effects. Adult stem cells, umbilical cord stem cells, and embryonic stem cells that have not been derived from embryos created for research can be used for these purposes. The creation of clonal human embryos, which would increase the difficulty of enforcing a ban on the production of genetic duplicate humans, is unnecessary for these investigations. This moratorium is prudent and reasonable policy when faced with a technology of such profound consequence.... More than 30 countries worldwide have already banned the creation of human clones and/or imposed constraints on the creation of clonal human embryos.... The future of our common humanity is at stake'²¹.

Geneticisation of Pharmaceuticals

Genetics and genomics in a way simplify scientific quest by trying to locate all sources of human behaviour in genes; it is certainly so in the case of disease and illness 'predispositions'. The lay public understands by this that there is much, if not all, of human life that is fixed and predisposed by our genes — not unlike our karma theory — and that there is little or no scope for looking into the social and political determinants of disease and susceptibility to disease. Inevitably, it sooner or later tends to lay the blame on the person with the disease. In reality, there is more evidence to show that only in a small fraction of cases can genes be correlated to disease occurrences; the gene function seems to be inherently unpredictable.

Equally important is the issue of who controls knowledge that is derived from studying genomic patterns. Do I have an 'intellectual

property right' over my genome and the knowledge/data/drugs derived from it? Clearly the public, and particularly the women on whom much of the genetic testing with respect to breast cancer and prenatal sex determination has taken place, needs to be told in clear terms the implications of these technological innovations – including its grey areas. The common man and woman must be able to participate in public and private decision-making concerning technological developments and their implementation. And given all the talk about right to information in India, this is one area where it needs to be operationalised as a priority. The quest for knowledge for its own sake may be wonderful and even romantic, but new technology and resource allocation for such technology must consider the question of whether it is likely to meet some of our social needs. Technofixes must not be allowed to obfuscate health problems that are essentially rooted in poverty and uneven distribution of resources.

There are other related concerns related to issues like informed consent (in genetic testing and counselling), confidentiality of medical records, and use/misuse of genetic information for jobs, adoption of a child, marriage, etc. The need for a debate on the ethics of marketing genetically derived pharmaceuticals is urgent. We need to ask:

'How does the pursuit of genetic tests, therapies and 'enhancements' affect our attitudes toward disability and our tolerance for difference and vulnerability among us all? How can we prevent genetic research from being used to further stigmatise particular racial and ethnic groups? These are human rights issues and debate about them must involve *all* of us, not only scientists, medical specialists and ethicists, but also policy-makers, religious groups, disability rights activists, social scientists, health care consumers and public health workers. We are, after all, much more than the sum of our genes'²².

Micronutrients and Pharmaceuticalisation of Health and Beauty

Health care in India is becoming increasingly pharmaceuticalised. The emphasis has shifted from food and nutrition, from coming up with a nutrition policy that addresses the causes of malnutrition by ensuring food security, to pharmaceuticalised micronutrients in the form of nutritional supplements.

Besides drugs, India is now home to the biggest international players in the cosmetics and beauty market estimated at \$ 4,000m²³ (equal to the pharmaceutical drugs market), and said to be growing at the rate of 30 to 36 per cent. Besides skin and hair care, a range of over-the-counter nutrition and food supplements are being marketed. However, not enough research about their possible adverse effects is available, for instance, on the safety of skin creams like the 'fairness' creams. Though India does have an Act that covers cosmetics – the Drugs and Cosmetics Act – the Drug Administration in India has very little time or human resources to monitor cosmetics.

Wastage of precious family resources, as well as national resources, on such non-essential and irrational drugs is probably our single most important drug-related problem. This economic loss for a nation in debt is totally unwarranted.

Post-Doha, India now needs to pursue health policies based on the principles of rational drug use and equity in health care more vigorously. It is in the interests of women and future generations of Indian's children to do so.

The patenting of indigenous knowledge and indigenous resources is a cause of great anguish for indigenous communities as well as developing countries from where biopiracy is taking place. India has fought legal battles over Neem and Turmeric, which have been part of India's health and healing heritage. Neem has been patented for its biopesticidal properties, which have been known for centuries. Other examples of biopiracy include the patenting of turmeric as an anti-infective, bittergourd (*karela*) and *Phyllanthus niruri* for hepatitis (Vandana Shiva 1997). Women who traditionally have been guardians of inherited wisdom about plant-based medicines are likely to be affected first by the biopiracy. Knowledge that was in the women's domain, and the public domain at that, is being sought to be commercialised and rendered inaccessible to common people (see also *Touch-me-touch-me-not, Women, Healing and Plants*, Kali for Women, 1997).

Notes

1. IMS MAT figures quoted in *www.Pharmabiz.com*, 14 February 2002.
2. For more detailed discussion on these aspects see: *LOCOST. A Lay Person's Guide to Medicine –What is behind them and how to use them*. Baroda, December 2000.
3. The failure of the Drug Controller of India to make public the brand list of the formulations banned, the reasons thereof and the alternatives available, continues to be a major block in spite of Supreme Court directions. For instance, very few doctors and chemists are aware that B1, B6, B12, have been permitted only for acute peripheral neuritis; analgin is to be used for severe pain only when not responding to other pain killers; and that oxyphenbutazone and phenylbutazone is permitted only for acute ankylosing spondylitis or acute gouty arthritis. Most doctors and consumers are not aware of these restrictions, as DTAB (Drugs Technical Advisory Board) decisions have not been communicated to them.
4. The National Family Health Survey 1998-99 shows that only 52 per cent of the women were involved in decisions about their own health. Out of the 39 per cent who had experienced a reproductive health problem like abnormal vaginal discharge, symptoms of urinary tract infection, pain or bleeding during intercourse, 66 per cent did not seek any advice or treatment.
5. 'GAO Study on women in clinical trials', quoted in A. Chetley's 'Women and Drugs' section of *Problem Drugs*, Amsterdam, HAI, 1993.
6. Chetley, *ibid*.
7. For more information see Chetley, *op.cit*.
8. Laurence, D.R and P. N. Bennett, P.N. *Clinical Pharmacology*. London, Churchill Livingstone, 6th Edn., 1987, p.85, quoted in Chetley, *op.cit*.
9. See, for instance, Trent Stephens and Rock Brynner. *Dark Remedy: The impact of thalidomide and its revival as a vital medicine*. Perseus Books Group, January 2001. See also the USFDA site at <http://www.fda.gov/cder/foi/label/2001/20785s12s14lbl.pdf>
10. Sathyamala, C. *An Epidemiological Review of the Injectable Contraceptive, Depo-Provera*. MFC and Forum for Women's Health (Pune, 2000). This book is compulsory reading for anybody concerned about the issue.
11. See, for instance, the sections on Oral Contraceptive Pills and Norethisterone in *LOCOST*, *op.cit*.
12. See, for instance, Barbara Mintzes et al. *Norplant: Under her Skin*. Women's Health Action Foundation and WEMOS, Delft, 1993.
13. See for research references on *What Are the Effects of Estrogen on Cancer?* at http://my.webmd.com/condition_center_content/mno/article/1680.52623
14. See footnote 13, *op.cit*.

15. <http://www.nhlbi.nih.gov/whi/hrt.htm>. Update on study on HRT by the National Institutes of Health (NIH), National Heart, Lung, and Blood Institute (NHLBI), USA.
16. Footnote 14, op.cit.
17. For more on the dispute and developments since, see <http://www.cptech.org/ip/health/sa/>
18. For more on the issue and developments since, see <http://www.cptech.org/ip/health/c/brazil/>
19. *Frontline*, 18 August 2001: Interview with Dr Valiathan, 'Clinical trials should promote health care'.
20. See *Frontline*, op.cit., Drug Trials and Ethics.
21. Statement on Cloning, Boston Women's Health Collective, June 2001.
22. *Genetics, Health, and Human Rights*, Boston Women's Health Book Collective position statement, May 1998.
23. India's \$4,000-m beauty industry goes bulk, *The Economic Times*, 26 November 2001.

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(For a more comprehensive bibliography/reference list, see LOCOST 2000.)

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Annexure 28.1

Drugs During Pregnancy and Lactation

Pregnancy

The most important rule when you are pregnant or intend to become pregnant is to consult your doctor before taking any kind of medicine, either prescription or over-the-counter (OTC).

Many drugs are known to cross the placenta (barrier between the mother's and the baby's bloodstreams) and cause adverse effects on the foetus (developing baby). Some drugs may also adversely affect the mother's health. There are certain drugs which are considered to be safe, but there is no firm proof of their safety and hence it is always better to let your doctor decide whether you should take a particular drug or not.

In some instances, when the pregnant woman is suffering from a chronic condition such as epilepsy, high blood pressure, diabetes or any kind of severe disease, it may become necessary to give her drug treatment. The doctor then balances the possible benefits and risks of the drug and decides if it should be taken or not. It is always preferable to avoid drugs for minor ailments. Drugs such as marijuana, nicotine (tobacco) or alcohol should also be avoided.

Effect of Drugs During the Different Trimesters of Pregnancy

The nine-month period of pregnancy is divided into three stages, each of three-month duration. These stages are called trimesters. A drug may exert different effects on the mother or the foetus or both depending in which trimester of pregnancy it is being used.

The first three months or the first trimester of pregnancy is the most critical period. Certain drugs may adversely affect the development of organs in the foetus. Very severe defects may result in miscarriage.

During the second trimester, drugs may retard the growth of the foetus, which can also cause low birth weight.

Drugs taken during the third and last trimester may cause breathing problems in the newborn baby or may cause premature/delayed birth.

Drugs in Pregnancy

Some drugs are dangerous throughout pregnancy. The table below lists drugs that definitely should not be given during pregnancy and those which are best to avoid if possible.

Drugs to be Avoided or Used with Caution During Pregnancy

<i>Drug</i>	<i>Avoid</i>	<i>Caution</i>	<i>Comments</i>
<i>Antibiotics</i>			
Chloramphenicol		3	Avoid using long courses. Causes 'grey' baby syndrome.
Co-trimoxazole		3	Can cause abnormalities and blood disorders in the baby.
Gentamicin		1,2,3	Only use if really necessary
Griseofulvin	1,2,3		Use topical drugs if really necessary
Metronidazole	1	2,3	Use lower doses (see following page for more details)
Nitrofurantoin		3	May affect the baby's blood if used near to delivery
Streptomycin	1,2,3		Can damage hearing of the baby. Note: treatment for TB should not be interrupted or postponed during pregnancy. Refer to your national TB guidelines for drugs of choice in pregnancy. If isoniazid is used, pyridoxine should also be given to prevent peripheral neuropathy.
Tetracyclines	1,2,3		This includes doxycycline.
<i>Anti-malarials</i>			
Halofantrine (Halfan)	1,2,3		
Mefloquine (Lariam)	1	2,3	Only use if no other drug is available.
Pyrimethamine/ Sulfadoxine (Fanisdar)		1,2,3	If possible use quinine instead
Quinine			This benefit outweighs the risk. Preventive measures are very important such as sleeping under a net and taking prophylaxis, e.g. chloroquine each week.
<i>Antihelmintics</i>			
Albendazole	1,2,3		Known to cause abnormalities in animal studies.
Mebendazole	1	2,3	Consider using piperazine if appropriate
Praziquantel		1,2,3	If possible wait until after delivery

Thiabendazole	1,2,3	Although thiabendazole is no longer on the WHO essential drug list, it may still be widely used.
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Analgesics

Aspirin & other NSAID	3	1,2	Use paracetamol
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Anti-epileptics

Carbamazepine	1,2,3	Benefit outweighs the risk.
Phenobarbitone	1,2,3	If possible use only one
Phenytoin	1,2,3	Use drug and monitor blood levels.

Miscellaneous

All cancer drugs	1,2,3	Seek specialist help.
Aminophylline/ theophylline	3	May cause irritability in the baby if used near delivery.
Benzodiazepines e.g. diazepam	1,2,3	Avoid regular and prolonged use.
Iodine	1,2,3	High doses can cause goitre in the baby.
Vitamin A (Retinol)	1	Large doses may cause abnormalities in the first trimester.

1 = first trimester (1-3 months) 2 = second trimester (4-6 months)

3 = third trimester (7-9 months)

AVOID = do not use at all

CAUTION = only use if the benefit outweighs the risk.

If the drug is not listed above it does not mean it is safe to use in pregnancy. Please check other literature for more information.

Source: *Practical Pharmacy*, April-June, 1998, Issue 9.

Lactation

Most drugs can pass from the mother's bloodstream into the mother's milk just as they pass from the mother's bloodstream into the baby's bloodstream. A baby who is being breast-fed will thus receive small amounts of the drugs that the mother is receiving.

There are certain drugs which do not pass into the mother's milk at all because of their chemical nature and there are some which do pass into the breast milk but in amounts too small to produce any harmful effects on the baby. However, there are certain drugs for reduced milk production in the mother that produce unwanted effects on the breast-fed baby. It is always advisable for the mother to consult the doctor before taking any drug while breast-feeding the baby. As far as possible, one must try to avoid drugs rather than breast-feeding. When the mother is

suffering from chronic conditions, and has to regularly take drugs, and the doctor should decide whether she should continue breast-feeding or not. In case she is allowed to continue breast-feeding, the baby should be closely monitored (observed) by the doctor for any possible harmful effects. It is important to remember that apart from a few chronic conditions, a mother is never advised to refrain from breast-feeding.

Advice on breast-feeding varies with the drugs prescribed. This is discussed in this column wherever necessary.

Drugs to be Avoided or Used with Caution During Breast Feeding

<i>Drug</i>	<i>Avoid</i>	<i>Caution</i>	<i>Comments</i>
Chloramphenicol		X	Only use if no other antibiotic is suitable.
Ciprofloxacin	X		
Co-trimoxazole		X	Especially if the baby has jaundice.
Metronidazole		X	Avoid large single doses e.g. 2g daily.
Tetracyclines	X		This includes doxycycline.
Others			
Aspirin	X		Use paracetamol instead.
Benzodiazepines e.g. diazepam		X	Avoid repeated doses. May cause weight loss and tiredness in the baby.
Carbimazole	X		May affect the baby's thyroid function.
Cimetidine		X	A significant amount is found in breast milk - not known to be harmful but advisable to avoid using.
Ephedrine		X	May cause irritability and disturbed sleep patterns in the baby.
Iodine (includes cough mixtures with iodine)	X		It appears that iodine is concentrated in breast milk and can severely affect the thyroid gland of the baby. If absolutely necessary to treat the mother then advise to stop breast-feeding.
Oestrogens (in oral contraceptives)	X		Reduces the milk supply. Choose an oral contraceptive that contains progesterone only.
Phenobarbitone		X	May cause drowsiness and inhibit the baby's suckling reflex.

Thiazide diuretics e.g. bendrofluazide	X	Large doses may reduce milk supply.
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If a drug is not listed in the table it does not mean that it is definitely safe to use. Please check other literature for more details.

Source: *Practical Pharmacy*, April-June 1998, Issue 9.

Chapter 29

Women, Work and Health
Issues for Consideration

Padmini Swaminathan

Misconceptions regarding women's work burdens partly explain the problem observed in some developing countries where 'development' has simply meant further additions to women's already heavy workload through the institution of 'income-generating activities'. The invisible, unaccounted and marginalised nature of much of women's work, coupled with minimal investments in basic infrastructure, have several serious consequences, a major one being the steady deterioration in the well being of the poor in general and of women in particular.

Here, we attempt to approach the issue of women's health by (a) mapping the multidimensional nature of their work; (b) addressing the contexts in which such work is carried out; (c) bringing together women's perceptions of their well being; and (d) analysing these perceptions for their links between 'work' and 'health'. *Section I* brings together, very briefly, data from two sets of studies. The first, based on a Time Use Survey conducted at the household level by the Central Statistical Organisation (CSO 2000) of the Government of

India, gives an idea of the time spent by men and women on different activities. While the study itself has been a pioneering initiative by the CSO, no attempt has been made to go beyond passively recording the statistical findings. However, the findings are significant, as they provide official recognition of the considerable and disproportionate amount of time that women (as compared to men) spend on the triple C (namely, cooking, cleaning and child care). This macro picture of women's work is supplemented with data from a micro-level study that captures the nature of the double burden that wage-earning women have to contend with on a day-to-day basis.

Section II discusses the macro context in which women work and live, the multiple disadvantages they face and the limited dent that macro policies thus far have made to ameliorate their work and living environments. This section also outlines the imperatives that need to be put in place for addressing the issue of health impact of work.

I.

Work, Work Intensity and Perceptions of Health

The fact that women remain responsible for domestic child and elderly care, regardless of whatever else they do, is by now well known and also fairly well documented, particularly by studies conducted at the micro level. For the first time, the CSO conducted a Time Use Survey in the states of Haryana, Madhya Pradesh, Orissa, Gujarat, Tamil Nadu and Meghalaya, representing the six different geographical regions of India, in order to quantify use of time by individuals aged six years and above in selected households. The CSO has since published its preliminary findings. The CSO's own conclusions from its survey are worth quoting:

- a) The amount of unpaid activities was more (51 per cent) for female as compared to only 33 per cent for male. The predominance of women in unpaid activities was visible in all the states (Table 29.1) (CSO 2000, p. 63).

Table 29.1

State-wise Distribution of Time Spent (in Hours) in SNA* Activities by Mode of Payment and Sex

States	Male			Female			Total	
	Paid	Unpaid	% Time on unpaid activities	Paid	Unpaid	% Time on unpaid activities	Paid	Unpaid
Haryana	33.09 (1152)	18.12 (1347)	35.38	4.13 (215)	25.37 (1494)	85.99	20.06 (1367)	21.37 (2841)
Madhya Pradesh	29.41 (5247)	23.34 (6311)	44.25	14.31 (3672)	15.75 (4391)	52.40	22.99 (8319)	20.12 (10702)
Gujarat	44.37 (3959)	14.17 (3897)	24.21	17.18 (1747)	13.87 (2541)	44.67	33.26 (5706)	14.05 (6438)
Orissa	31.25 (2103)	22.42 (2589)	41.77	8.00 (583)	18.18 (3235)	69.44	20.55 (2686)	20.47 (5824)
Tamil Nadu	41.42 (5633)	13.36 (4863)	24.39	21.48 (3034)	10.32 (4280)	32.45	32.74 (8667)	12.04 (9143)
Meghalaya	17.34 (374)	35.39 (740)	67.12	7.83 (196)	25.34 (692)	76.39	12.65 (570)	30.44 (1432)
Combined states	36.54 (18468)	18.12 (19747)	33.15	14.87 (8847)	15.18 (16633)	50.52	27.16 (27315)	16.85 (36380)
								38.29

Note: * SNA activities classified under the System of National Accounts followed by the Government of India in its computation of National Income of the country.

Figures in parenthesis in the second line under each activity denote sample number of persons participating in the activity.

Source: Government of India 2000, p. 63.

- b) Whatever characteristics we take (age, sex, marital status or educational level), it was generally found that females spent about double the time as compared to males in the care of children, elderly, sick and disabled. The time spent by currently married and widowed females was found to be higher than those for never married and divorced. It is also an interesting finding that females aged 60 years and above were found to be spending maximum time as compared to those in the age group 6-14 and 16-59. No significant impact of educational level was found in such activities (Tables 29.2 and 29.3) (CSO 2000, p. 66).

Problems associated with the collection, interpretation and analyses of data notwithstanding, the significance of CSO's study on Time Use lies in the fact that, for the first time, there is *official recognition* of several aspects of women's work, that had hitherto been the exclusive struggle of the feminist movement in India. These include:

- a) The *visibility* accorded to the nature and diverse range of women's work;
- b) Documentation of the fact that much of women's work, though economic in nature, remains *unpaid*;
- c) Recognizing, *albeit implicitly*, the fact that women's preoccupation with household activities has a direct bearing on their participation in paid activities, particularly those that need to be performed outside the *immediate* household.

What the CSO data does not capture is:

- (i) The *intensity* or the effort expended on each of the tasks performed; and
- (ii) The *overlapping nature* of each of the activities.

This, as Floro (1995) says:

'tends to create a systematic bias in the data; time devoted to certain activities such as child care, for example, tends to be underestimated. Given the gender imbalance in household divisions of labour, there is a resulting

tendency to underestimate the extent of gender asymmetry between female and male household members.'

The issue of work intensity is extremely important since it has a direct bearing on well being. There are hardly any studies that *assess* the impact of work intensity on health, despite the empirical awareness that poor households have to cope with heavy workloads on a day-to-day basis, and much more when real wages fall, prices rise and basic services are cut. The harsh conditions under which household duties have to be performed need to be placed alongside the unhealthy atmosphere in which wage work is carried out. The nature of the stress that working women have to cope with is illustrated by a micro-level study entitled the 'Costs of Work' (Jeyaranjan and Swaminathan 2000).

The 'Costs of Work': Findings of Micro-level Study

The main objective of the study was to document the nature of women's work, the conditions under which the work is carried out, and women's perception of the health impact of their working and living environment. The location of the study is the district of Chengalpattu in Tamil Nadu. The district itself is undergoing rapid transformation from being a predominantly agrarian-based economy to an industrial one. Not only is the occupational profile of the population undergoing a change but also the earlier, most important resource of the region, i.e., land, is increasingly being put to non-agricultural use. The district is thus witnessing an increasing growth of non-farm employment in industrial units that are coming up and/or expanding along the periphery adjoining Chennai city.

It needs to be stated that not all the units that are coming up are illegal or informal; however, much of the employment offered is informal in the sense of being insecure and unprotected. Most of those employed have no legal recognition as 'worker' and are employed on a temporary, casual or daily basis. For all workers — men, women and adolescents — the conditions of work are extremely harsh and unhealthy. Given the lax attitude of officials and trade

Table 29.2
State-wise Weekly Average Time (in Hours) Spent in Care for Children, Sick, Elderly and Disabled
for Own Household by Age, Sex and Marital Status

Age (Years)	Sex	States					Combined States
		Haryana	Madhya Pradesh	Gujarat	Orissa	Tamil Nadu	Meghalaya
6 to 14	Male	3.62	13.40	7.29	6.99	5.28	14.53
	Female	7.08	12.91	11.39	12.41	5.49	17.64
	Total	5.97	13.10	9.75	11.27	5.40	16.60
15 to 59	Male	5.54	5.35	5.85	9.48	5.33	5.88
	Female	13.03	10.89	12.92	13.62	11.95	12.50
	Total	11.39	9.46	10.58	12.58	9.96	10.29
60 and above	Male	13.08	11.21	9.44	10.24	7.05	7.53
	Female	18.15	16.69	15.94	16.33	10.57	12.38
	Total	17.02	15.11	13.36	14.30	9.07	10.14
Total	Male	5.87	6.88	6.23	9.42	5.46	6.92
	Female	13.08	11.37	12.98	13.70	11.61	13.08
	Total	11.46	10.14	10.69	12.61	9.67	11.00

Table 29.2 (contd.)
Marital Status

Never Married	Male	3.79	11.26	6.08	7.34	4.39	8.92	7.24
	Female	7.19	12.21	11.58	10.85	6.42	14.31	10.39
	Total	5.96	11.82	9.41	10.19	5.47	12.34	9.20
Currently Married	Male	6.12	5.52	6.15	9.49	5.66	6.04	6.41
	Female	13.25	11.07	13.11	13.93	12.38	12.96	12.54
	Total	11.70	9.66	10.74	12.71	10.33	10.49	10.76
Widowed	Male	9.88	9.70	8.65	15.06	9.79	13.29	10.28
	Female	18.12	14.74	14.34	17.77	10.85	12.83	14.21
	Total	17.35	13.71	13.17	17.39	10.75	12.92	13.60
Divorced/ Separated	Male	---	4.14	9.20	3.67	4.06	---	5.53
	Female	7.00	11.79	7.43	9.09	13.37	9.92	10.18
	Total	7.00	9.80	7.98	8.04	9.38	9.92	8.86
Total	Male	5.87	6.88	6.23	9.42	5.46	6.92	6.65
	Female	13.08	11.37	12.98	13.70	11.61	13.08	12.38
	Total	11.46	10.14	10.69	12.61	9.67	11.00	10.69

Note: The entry ' - ' in a cell indicates that no corresponding observation was found in the sample.

Source: Government of India 2000, p. 65.

Table 29.3 State-wise Weekly Average Time (in Hours) Spent in Care for Children, Sick, Elderly and Disabled for Own Household by Education Level and Sex

Educational Level	States							Combined States
	Sex	Haryana	Madhya Pradesh	Gujarat	Orissa	Tamil Nadu	Meghalaya	
Illiterate	Male	6.04	7.44	7.55	9.23	4.16	5.10	7.71
	Female	13.92	11.39	14.03	14.09	11.74	11.96	12.83
	Total	13.24	10.73	12.81	13.33	11.03	10.14	11.99
Literate below Primary	Male	5.70	5.90	7.19	8.50	4.66	7.51	6.54
	Female	10.11	11.26	13.11	12.35	10.63	13.94	11.70
	Total	8.90	9.40	10.87	11.30	9.34	12.09	10.11
Primary	Male	5.47	8.30	5.30	8.20	5.41	7.51	6.35
	Female	13.22	11.20	11.60	15.22	10.45	13.97	11.79
	Total	10.91	10.08	9.06	13.36	9.19	11.89	10.05
Middle	Male	7.28	5.24	6.01	9.45	5.47	5.08	6.19
	Female	12.55	12.19	12.65	12.64	12.11	12.14	12.38
	Total	10.17	9.55	9.61	11.59	9.81	10.15	9.99
Secondary	Male	4.72	8.03	5.47	9.52	5.08	8.80	6.30
	Female	11.97	10.89	11.04	12.50	13.57	11.52	12.11
	Total	8.85	9.57	8.82	11.23	9.95	10.12	9.66
Higher Secondary	Male	6.49	6.38	4.98	13.68	5.04	8.31	6.22
	Female	11.18	11.51	10.81	15.55	12.11	17.11	11.97
	Total	9.29	9.09	8.00	14.77	8.98	12.35	9.34
Graduate and above	Male	4.97	6.81	6.05	11.30	5.33	6.66	6.45
	Female	12.42	10.18	13.79	13.72	11.40	12.20	12.10
	Total	8.60	8.13	8.98	12.42	7.90	8.96	8.79
Total	Male	5.87	6.88	6.23	9.42	5.46	6.92	6.65
	Female	13.08	11.37	12.98	13.70	11.61	13.08	12.38
	Total	11.46	10.14	10.69	12.61	9.67	11.00	10.69

Source: Government of India 2000, p. 66.

unions, combined with the abundant availability of 'upwardly mobile oriented' youth, the employers are under no pressure to invest in labour or in providing safe workplaces.

Observations Based on Narratives

Nature of stress experienced at home and at the workplace: In almost all the cases involving women workers, there is evidence of many spaces that are being straddled simultaneously and the constant negotiation that goes on to keep to time and targets. The workday for the women, and married women in particular, stretches over almost 16 to 18 hours, leaving them exhausted. In fact, 'tiredness' is the single most common complaint recorded. In a sense, therefore, lowering the burden of work as well as raising the capacity for work would go a long way in alleviating the impact of excessive work.

For most women (married as well as unmarried, with intensity increasing for married women) the daily work schedule is somewhat as follows: their day starts around 4.30 or 5.00 a.m. Wood is the main fuel for cooking while water has to be fetched from the roadside pump. After almost three hours of 'work' at home, they have to rush to catch a vehicle (either a public bus or company bus) to the factory. In the absence of any alternative mode of reaching the factory, missing the bus is tantamount to losing the day's wages. The stress involved in leaving home to catch the bus to reach the workplace in time, is enormous. Almost all women workers reported inadequate time to have any meal before leaving for work.

Similarly, there is no way in which women can relax immediately on getting back home after a day's work. Again, her work stretches for almost three to four hours before the woman can call it a day. Women with small and/or growing children are particularly stressed since, if they fail to cook the evening dinner within a reasonable period of time, they have to put up with the guilt of seeing their children go to sleep on an empty stomach. Very few women reported receiving support on a regular basis from their partners or the male members of the household. Besides, on days when the public tap goes dry, or some other calamity befalls the household, the strain on

the women is so enormous that she has to forego her leave or wages or both.

The nature of stress experienced at the worksite is not just varied but also subtle. It begins at the gates of the factory where workers are grouped into batches; young women have almost no say in the choice of batches. The organisation of batch work, coupled with the pressure to meet targets, very often means that workers can hardly take time off even to visit the toilet. In fact, most units regulate work time so strictly that they close the toilets 15 minutes before closing time. For menstruating women, the ordeal of dealing with such a requirement is so enormous that they end up absenting themselves on such days.

All women use only cloth as protection during menstruation. There was no facility at any of the units covered by the study for women to change the cloth during working hours. Thus, in extreme cases of severe bleeding or cramps in the stomach, women just stay away from work. Not only is the workload in the factory not reduced during these days, women, especially those working in batches, cannot ask even for a small reduction since the entire batch is penalised if targets are not met.

Since most women are unable to eat any meal (for want of time) before leaving for work, the first solid meal taken by them is around noon. These women attribute their complaints of constant stomachache and acidity to the prolonged gap in intake of food spread over their working day.

Enormous significance is attached to the content of the food carried by the workers. Eating leftover rice and/or curd-rice is so looked down upon that it inhibits the carriers of such food from eating with other colleagues. Similarly, carrying relatively large tiffin boxes is also ridiculed, while smaller tiffin boxes and eating snacks rather than rice are seen as 'modern'.

Conditions of work: The study covered workers in the following industries: screen printing, salt loading and packing, beverage and essence making, dyeing, leather shoe factory, mixers and gas stove

manufacturing company, and pharmaceuticals. Thus, almost all the workers interviewed come in either direct or indirect contact with some chemical or the other in the course of their work. The women workers provided the following descriptions when asked to describe the specific nature of their job in the unit and their perception of the health problems associated with it:

- a) A bottle washer in a pharmaceutical firm has to physically wash thousands of bottles continuously throughout the day. At the end of the day, she is barely able to lift her hands and is in considerable pain. Bottle washers have to also contend with the added phenomenon of being injured by glass pieces when bottles break in the course of washing.
- b) Those employed in the capsule-filling unit have to be extremely alert to cope with the speed of the machine. The women workers came up with umpteen examples of their friends and neighbours who have been maimed because their fingers have got caught in the machine while handling the tablet strips. A number of these maimed workers have had to quit their jobs.
- c) Salt workers complain that the salt produces intense heat and affects the body as a whole. Some workers attribute the constant dysentery and stomachaches they suffer from to this intense heat. Constantly watching the white salt, according to the workers, has led to blurring of vision. Skin irritation and itching of all those parts of the body that come into contact with salt, is a common complaint among all salt workers.
- d) Leather workers also complain of constant itching in the hands and legs as a result of handling leather. It seems that the company provides an ointment (white in colour, name not mentioned), which *initially* is quite effective. Again, according to the workers, the leather they handle is infested with some small insects, which they feel could be the cause of the itch.
- e) Checkers in the garment industry complain of severe sneezing because of dust from the cloth (*gada*). The *gada* is bleached with acids and chemicals and every piece is required to be

minutely checked before being sent for dyeing and/or printing. Nasal congestion, headaches and cough are other common ailments among these workers. One of the checkers interviewed had resigned after she vomited blood at the workplace. She had worked for two years. While in her job, she had no time for breakfast. Her work also required that she continuously remain standing. Among those employed in the sewing section, back and hip pain is a common complaint. By evening, most of them complain of severe pain in the neck.

- f) Most workers complain of the constant foul smell that pervades the entire workplace, be it pharmaceuticals, mixer manufacturing or leather shoe factory. This, in turn, creates nausea and loss of appetite among the workers. In conjunction with going to work on an empty stomach, this could to some extent account for the periodic feelings of giddiness, acidity, etc., expressed by the workers.
- g) Unmarried women workers, as also their parents, have to cope with the general stigma that has become associated with women working in a particular industrial estate.
 - (i) The engagement of several women has been broken when prospective grooms learnt of their place of work;
 - (ii) In an effort to control women's sexuality, parents, near relatives, employers, supervisors, etc., resort to all kinds of repressive tactics at home, in the workplace and outside the workplace.
- h) Every worker interviewed was asked to recount any unforgettable incident(s) in their experience. Almost all those who responded spoke of injuries and accidents that their colleagues at the workplace have met with, which have left a deep mark on the respondent's life.

The pressure on the workers is kept up by fixing targets for each of the work processes. In bottle washing, the usual demand is to wash 1000 bottles per day per worker. However, the workers manage to

wash only 700 to 750 bottles in a day. Targets in packaging and filling vary, depending on the size of the bottle and the capsule or tablet. In strip packing, 9000 to 10,000 pills are expected to be packed. In filling, the minimum requirement is 250 bottles. In packaging, a four-member team has to pack 60 boxes, each containing 100 bottles. Each batch taking has a target of 600 litres of the raw concoction. If a mechanised material handling system is in place in the production unit, fillers have a target of filling about 6000 bottles during a shift. The target list is a long and detailed one, varying with the nature of product, level of mechanisation, nature of the input material and the packing requirements. However, what is clear is that these targets are stiff and the workers have to be on their toes to keep pace with the machines. The workers experience the increased intensity of the work process with an insistence on keeping to targets, particularly when order books overflow; at such times, even working overtime does not help.

In some units protective gear is provided to the workers. But this gear hinders the rapid movement of workers, who complain that it is impossible for them to achieve the set targets while wearing it. Hence, most of them do not use the protective gear. The problem, however, could be a combination of both: stiff targets that are set without any consideration for the gradual slowdown in the bodily movement of the workers, as well as the inappropriate design of the protective gear. Besides, most factories do not make it mandatory for workers to wear any protective gear.

Relationships between women workers and male supervisors/colleagues form another area that generates enormous stress. The women interviewed were able to discern the subtle manner in which they experience discrimination; younger, relatively better-looking and better-dressed women were able to wrangle several favours from their supervisors, such as choosing the batches they preferred to work in, promotions, etc. The day-to-day operation of such discrimination at the worksite has inhibited the emergence of any solidarity among the women workers.

Given the nature of work conditions in the industrial units of the

district, the workers in general perceive that their health condition is deteriorating. And yet, despite the long hours and the harsh working conditions, despite the stigma attached to working in units in the industrial estates, the narratives of these women suggest that the opportunity for employment is generally regarded as a positive development. Factory work is considered to be modern and therefore superior to agricultural work despite the long hours it demands. Most adolescent workers are able to negotiate within their natal families some independence and autonomy as a result of their earning potential, while remaining aware that a traditional marriage will end this phase of their lives.

Since the research team was not equipped to conduct clinical tests, and/or even initiate epidemiological studies, it had perforce to rely on the respondents' own perceptions of their well being. While this methodology is grossly inadequate to establish any degree of causality between a particular 'work' and its attendant health outcome, the strength of the investigation lies in the enormous amount of insights that it gives into the manner in which people's lives are ordered in particular socio-economic contexts. As Jackson and Palmer-Jones (1999) point out,

'(The) burdensomeness of work, and its implications for well being, is not only a function of its physical arduousness, it is also related to the social relations and valuations of work and personal experiences of the pleasure and the pains of work.' (pp. 560-61).

II.

Macro-Concerns: Policy and Research

The particular manner in which development is taking shape in our society involves high work intensity, stemming from a combination of enormous energy expenditure both *at home* and at the *workplace*, which is damaging to the well being of a person. Large sections of our country's population suffer extreme poverty and deprivation.

These sections heavily depend on physically arduous activity in both agricultural and non-agricultural livelihood. This immediately implies that lowering the burden of work as well as raising the capacity for work could go a long way in alleviating poverty in a nutritionally challenged population. In this context, Jackson and Palmer-Jones' (1999) concept of 'body capital' is especially useful, since it immediately focuses on the endowment that poor people rely on more than any other, namely, their bodies. 'If bodies are seen as valuable assets for the poor, and for women, we question whether development policies should encourage them to be extravagantly squandered in effort intensive activity' (ibid. p. 562).

Workers in general, and women workers in particular, in the less developed countries are disadvantaged at various levels. The nature and pattern of economic development has been such that the bulk of employment has been generated (and continues to be so) only in the informal sector with its attendant evils of little or no protection. Moreover, wages are relatively low, and worse, the work conditions are unsafe and unhealthy. Most workers are too vulnerable to register their protest against any of these disadvantages. Their situation becomes even more vulnerable when viewed from a gender perspective, since at every level the disabilities that women have to suffer are several times more intense when compared to male workers. It is our contention that these problems cannot be redressed within the existing legislative and administrative framework *alone*, since the latter is not geared to address and tackle such structurally in-built inequities.

An equally important and related issue that needs to be addressed is how to net information about occupational effects on women's health problems. Although different bodies of researchers are beginning to produce information on health problems in some women's jobs, this knowledge does not form part of the database of policy-makers. In a sense, it is futile to expect policy-makers to address women workers' occupational health issues when most women still do not have, officially, a 'worker' status.

Coming to the issue of generation of information on occupational health *per se*, 'women's health problems are relatively invisible to scientists because they are using inappropriate methods' (Messing 1997, p. 16). Even in developed countries, scientific studies of health consequences of women's work have systematically been omitted because of a perception that not many women get occupational diseases. The cumulative effect of such neglect is that there are few prevention programmes in jobs where women are employed. Consequently, hazards are not discovered and standards are not developed for these jobs; this, in turn, implies that when women experience health problems, they cannot claim compensation based on known risk factors. The tendency by and large is to dismiss women's discomfort at work as being the result of 'personal weaknesses, psychological difficulties or imagination' (ibid. p. 17).

The immediate requirement is to build a credible body of information on the health impact of women's work, for which indicators will have to be innovatively devised. A few of these have been indicated by Messing (1997) and deployed in her own studies. These indicators, or at least the principles underlying them, can be successfully applied to the situation in India.

The Messing indicators have been developed in consultation with the workers involved and represent what the workers consider to be critical aspects of their jobs. Further, the indicators arise from observations of the work actively *in situ*. Points (i) to (iv) draw liberally from Messing's (1997) work.

- (i) For certain factory and service jobs, it is important to consider *repetitive gestures* and to *count the number of times* a gesture is made, since repetitive movements can cause musculoskeletal disease (emphasis added, p. 21).
- (ii) Some repetitive gestures involve the use of force, and the total amount of force exerted may be an important determinant of joint inflammations. Ergonomic standards for the workplace generally concern the types of lifting all at once. This standard setting is not appropriate for those jobs, usually held by women,

where small forces are exerted repeatedly even though the cumulative force may be greater. For the type of lifting more common among woman, limits should be put on the total force exerted in a day (p. 21).

- (iii) Light work/heavy work comparisons have been made in cleaning jobs and show that women in light work are exposed to postural constraints. For example, the examination of the sequence of objects dusted by women cleaners in a hospital showed that cleaners spent 74 per cent of their working time with their trunk flexed. Ergonomic standards do not cover the proportion of time spent in a flexed position although such limits could be set (p. 21).
- (iv) Because regulations have evolved in relation to a male-pattern lifestyle, the need to meet family responsibilities has not always been included in labour standards. Workers, usually women, who must arrange for child care in order to work, bear this burden alone. Messing compiled child care arrangements made by 30 telephone operators (with children under 12) who received their schedules every Thursday for the week starting three days later, on the following Sunday. These operators kept records for two weeks. Messing notes that these operators made a total of 156 attempts to change their work hours (5.1 per operator) to meet family responsibilities. On the average, less than one of these succeeded (p. 22).

In a context where even basic infrastructure such as fuel, water and sanitation is not in place, the combination of household chores and factory work for women workers in particular, leads to not just enormous stress and strain but also disease and ill fare. While the resolution of the problem of investment in basic infrastructure and in making workplaces safe and disease-free needs to be done at the macro level, an equally important amount of research time, money and effort needs to be invested in making *visible* the *nature* and *magnitude* of occupational hazards and diseases that workers in general, and women workers in particular, are prone to. The emphasis on women workers stems from the fact that the structure and

organisation of households, workplaces, and institutions like trade unions, labour departments, etc., are so gender-biased, that much of what women do, experience and suffer remains invisible and hence unaccounted, thereby adding to the marginalisation and devaluation of women's work and health status.

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*Chapter 30***Dilemmas of Women's Activism
in Mental Health¹**

Bhargavi V. Davar

During the early years of the women's movement, women's 'mental distress', 'insanity', 'hysteria' or 'neurosis' was seen as a form of subversive 'protest'. It was seen as a woman's manner of saying 'no' to oppressive social circumstances. The psychiatrically labelled women were seen as part of the larger women's collective challenging patriarchy in their own way. However, the label of 'insanity', in contrast to other disease categories, e.g., 'diabetes', divides people politically. It divides people into those who are rational and competent enough to participate in civil society, and those who are not. In this understanding, many constituencies, including women and children, were seen as below the normality mark. Since the women's movement was inclusive, it saw no meaning in the normality/abnormality debate, which signalled political exclusion in every sense. All women just participated in the movement without having to first prove their 'capacity' on the basis of some rationalistic standard! And all women being equal, 'women's mental health' was never an issue to merit a special universe of discourse.

However, the women's movement itself was empowering of women's inner world and everyday life. Even though it was not called so, in the psychological benefits and effects that it brought to individual women, it was like a mental health movement (in the sense that all social movements in a way are mental health movements.) The women's movement gave thousands of broken and wounded women healing space where they could be themselves without being judged or evaluated. They had the support of other older, stronger women from whom they could learn about survival, resilience and resistance. When, for one reason or another, their families abandoned them, the women's movement cleared space for them, gathered up their resources and offered them for sharing — often in their own homes.

Generations of activist women have nurtured and cherished the culture of resistance in which younger women have been socialised and 'brought up' as it were. The women's movement gave these younger women a life-affirming perspective about themselves, about being a woman, about being embodied, about being a bundle of mixed emotions, about being beaten and scarred, and about being in equal relationships — which they failed to get from their own life contexts. Women learnt how *not* to feel *guilty* all the time and how *not* to beat themselves emotionally. The women's movement gave many women ways and means of *externalising* their anger and guilt, finding outside objects into which they can be meaningfully channelled, thus saving them from depression and suicide. It also gave them the nurturance of friendships, otherwise rare in women's lives. It gave them a sense of community that they couldn't experience at other times.

For many women, being with the movement inculcated in them a feeling of self-worth, which repeatedly validated them. If therapy may be described as *transforming* individuals from a sense of being trapped in something very nasty to a sense of being free, then the women's movement was therapeutic. None of this, however, was *cast* in a mental health language.

In the post-Independence era, the Indian women's movement was strongly rooted in the left ideology and disdained anything that was 'personal'. Vindhya (2001) has analysed that the women's movement

and mental health sciences are founded on ideologically opposite principles about human beings: collectivism versus individualism. The former is based on the axiom that the 'personal is political', which has been repeatedly substantiated in using 'gender' as an analytical category while examining the private sphere. There can be no 'private' sphere outside the scope of political analysis. Notions of 'personality', 'self', 'autonomy', 'privacy', 'consent', etc., which form the technical and ethical backbone of the mental and behavioural sciences, have been contested by the movement. It has been necessary to show how scientific power, which is patriarchal, rules emotions, cognition and mentalities, and regulates women's inner worlds and individual behaviour in society. As with other disciplines, the political basis of the mental and behavioural sciences also needed to be questioned.

In classical psychology, the individual is postulated as the site of change and as the basis of social policy, welfare and service activities. There is the nearly karmic assumption that behavioural outcomes are due to an individual's own (psychological) action and that people (should) get only what they deserve (e.g., the common assumption underlying AIDS policy/law/interventions in India). With the state withdrawing from the direct role that it played in social welfare, two aspects reinforcing individualism have crept into policy. In nearly every area, the state is forcing individuals and communities to be accountable for their own health. Secondly, it has allowed market forces in health and mental health to freely exploit the idea that physical and emotional fitness can be bought and sold and that it is all up to the 'consumer'. Is the long-stay in-patient of a mental hospital a 'consumer'? Is the 'wandering lunatic' rounded up by the police and incarcerated within jails or mental hospitals, a 'consumer'? Is the involuntary psychiatric patient a 'consumer'?

Macro-level political, social or systemic issues are not taken into account in policy making, and when individuals fail to fit this individualistic model, as they invariably will, they only have themselves to blame for having certain 'immutable' personality traits or 'lifestyle' problems that hinder them from conforming. This is

how the mental and behavioural sciences maintain the status quo and assist the state by regulating individual behaviour, quelling dissent and maintaining the social order. In the feminist context, the technological and institutional instruments of the sciences fostered women's given social roles, social hierarchy and cultural hegemonies of gender, class and caste. This is true of the mental and behavioural sciences as well.

Women and Psychiatry

The women's movement increasingly recognises that certain subjective experiences are indeed experiences of social powerlessness rather than experiences of empowerment or self-conscious protest. Friends who had a 'problem' sometimes were preoccupied with their personal experiences and withdrew, socially. They did not automatically choose the social or political forms of self-expression when in an 'episode'. Also, with the increasing entry of middle-class women into the psychiatric regime as 'patients', diagnosed women and their medical-social reality had to be addressed. Not naming psychological distress as psychological distress, and calling it something else, like 'metaphor', as the anti-psychiatrists did, or as feminist 'protest', left women with these personal experiences without a critical language when they went for 'treatment'. The diagnosed women, e.g., with domestic problems *and* depression, often had to straddle on their own, the women's movement, mental health services as well as their life situations, as women's groups did not have the language to help them. Of course, the movement did enable the formation of meaningful friendships and sharing of experiences — friends with a diagnosis, friends who understood and offered support, professional friends who were feminists, lesbian friends. These friendships have found spaces within the women's movement.

Vis-à-vis the mental health and behavioural sciences, the broad trend of the women's movement has been to:

- Critically examine gender bias in mental health theory and

practices from a socio-political perspective.

- Especially question diagnostic practices related to women (hysteria and possession are some evident examples. A more recent concern is the misdiagnosis of victimisation and trauma-related experiences like 'depression' or 'anxiety').
- Re-script the domain of women's mental health from a feminist point of view.
- Negotiate with the mental health laws, policy and services so that women may use those services more assertively and in their own interest, instead of under duress.

There have also been innumerable efforts at opening feminist alternatives in counselling and supportive therapy.

A Brief Review of Data

- Samples from psychiatric surveys in rural/urban, north/south Indian communities in India done between the late 1960s and 1990, average a diagnostic rate of about 11 per cent, with men averaging 10 per cent and women 15 per cent (Davar 1999).
- In these surveys, around 1 per cent men and 1.3 per cent women received a diagnosis of Severe Mental Disorder (SMD) (including organic brain syndromes, epilepsy, mental retardation, psychoses), whereas 6-7 per cent men and 10-11 per cent women, received a diagnosis of Common Mental Disorder (CMD) (including depression, anxiety, psycho-somatic and other neurotic symptoms) (Chakraborty 1990; Sandel 1990; Davar 1999).
- Independent (Indian) surveys on depression and neuroses show that a lot more women than men receive diagnoses of CMD, such as anxiety, depression, somatisation, phobias and obsessive compulsion.
- Twice the number of women than men is believed to be 'depressed'. According to recent world databases, depression is

the fifth highest-ranking disorder in women across the world (Desjarlais et al. 1995).

- About 12-15 per cent women in community samples may report pre-menstrual distress. For 13 per cent women reporting such distress, the symptoms may be intolerable (Chandra 2001). Post-partum depression is common and, in a small number of women, severe enough to require intervention.
- The statistical association between childbirth and symptom formation is strong (Sandel 1990, p. 174). A small but significant sample of women develops post-partum psychoses, which is often neglected (Chandra 2001).
- Approximately 17.9 per cent of women in the community report CMD (Jaswal 2001). There is a strong correlation between gynaecological morbidity and CMD.
- More women than men use the so-called indigenous healing systems (shamans and mystics), are possessed, or go into mystical trance.

Common mental disorder or 'CMD' is said to be of greater prevalence among women. Some emerging concerns in the area of CMD among women are: the mild to serious mental effects of victimisation by violence, especially child sexual abuse; self-injury and suicide, especially among adolescent girls; and eating disorders, following the post-liberalised media onslaught of images of thin and ravishing women. The psychological impact of violence on women is comparable to the effects of trauma, disaster or war. Higher rates of suicide, greater use of health services, and a range of diagnoses from anxiety to severe mental illness may result from victimisation. It is estimated that one out of five healthy years is lost to women in the range of 15-44 years due to victimisation. The health burden for victimisation is 9.5 Disability Adjusted Life Years (DALYs), comparable to costs of HIV, TB, cardiovascular disease and maternal morbidity.

In the West, recent authors have emphasised, especially in the context

of the astounding information on victimisation by violence, that women's mental health must be seen within an epidemiological and public health perspective (Lubotsky et al. 1998). However, such re-organisation of priorities should not underestimate the life situations or the service needs of severely ill women. The common mental health problems of elderly women or women suffering from disabling illness such as osteoporosis, cancer, etc., are not known.

While there is a great need for woman-friendly mental health services, few options are available at the ground level. The in-patient facilities (private, public hospitals, general hospital psychiatric wards, and other private residential facilities) have fewer beds for women. However, in itself, this is a fact for rejoicing, given that institutional care is highly oppressive and dehumanising. Severely ill women are often seen as genderless in in-patient facilities (Addhlakha 2001). Such facilities, especially in mental hospitals, do not serve the special physical health needs, for example, pregnancy, gynaecological or menopausal problems, of women. Rape and sexual abuse of institutionalised and ill women (by hospital superintendents), who are then sent for clandestine abortions, are not unknown. Women's expression of disapproval, anger or resistance within in-patient facilities is likely to be interpreted as evidence of their illness. Institutional care offers little by way of rehabilitation. Strong gender stereotypes operate within in-patient psychiatric settings where 'abnormality' and 'cure' are defined in terms of conformity to a notion of femininity.

The abuse of over-the-counter medication is largely unresearched, though experientially, activists have always worried about the over-prescription of tranquillisers, sedatives and anti-depressants (Shatrugna 1999). It is known that Indian psychiatrists over-prescribe drugs (Nunley 1996), do needless psychosurgeries and use Electro Convulsive Therapy (ECT) indiscriminately or in a cavalier fashion (Agarwal et al. 1990, 1992), without taking ethical issues (providing information or consent) too seriously. The American Psychiatric Association (1990) sanction of ECT use has worsened the situation. It has led to renewed enthusiasm for the treatment while not covering

for any type of patient safeguards. Ethical codes for the safe administration of the treatment, and the technology required, are near absent in Indian hospitals.

In a recent study (Agarwal et al. 1997) of professional attitudes to ECT, it was found that an overwhelming 76.8 per cent of psychiatrists favoured its use, while only 2.7 per cent had strong objections. A majority *disagreed* that 'ECT should be used only when all else failed'. Relatives of patients, too, overwhelmingly preferred ECT and drugs to psychotherapy (Boral et al. 1980). But not even one patient voluntarily chooses ECT (Verghese et al. 1968); most of them are forced to take what is chosen for them by professionals or relatives. It is not likely, as in the West, that women are given more of these physical treatments, because except for community care settings, women's access to mental health care in India is meagre. However, it *is* likely that women who do enter treatment settings are regularly abused by ECT and are over-prescribed psychoactive drugs.

Dilemmas of Legal Activism in Mental Health

Dhanda's work (especially 2000) has led to important and critical advocacy positions in law, while not forgetting the social vacuum within which such positions have to be played out. Other campaigns for rights of the mentally challenged, e.g., the case of the Sirur hysterectomies, have highlighted the problems of having to protest indignity in a socially unsupportive and politically bankrupt environment. Lawyers expect legal reform and activism to keep pace with scientific progress (Dhanda 1993). The larger issue is, of course, how far we can take the scientific discourse to be free from gender biases (Davar 1999). Legal reform, in order to be effective, must be equally supported by changes in social attitudes, social policy and sexist attitudes and practices within the mental health services.

Dilemmas of legal activism must be understood against the social context of apathy and stigma against the mentally ill. For example, apex court decisions following public interest litigation to release 'non-criminal insane' from jails in West Bengal (and also other parts

of India) was a legal victory from a 'rights' position. However, it became questionable (as happened in the West after the de-institutionalisation process) because policy support was completely lacking from the state. Nor were the communities willing to take on a care-giving role. The wrongly incarcerated persons were simply released into the streets without the state providing alternative or appropriate care. The community raised objections about the poor and homeless mentally ill wandering the streets, and from a different perspective, *this* became a human rights issue.

The limitations of activism in mental health and taking on a rights position, therefore, has to be assessed versus the

- absence of an active people's movement in mental health to support that activism, and the
- absence of policy support and the very poor availability of alternative community services to mainstream psychiatric and institutionalised services.

In the absence of community-based information and documentation on Indian women's psychological experiences, legal activism and policy advocacy for women's mental health is problematic. There needs to be a community-based people's movement to support and carry forward this advocacy work. People, and especially women, with a psychiatric diagnosis must participate as a political community in order to be enabled by legal or policy advocacy. If advocacy happens at the initiative of professionals or activists without the community's participation, it would be just another form of paternalism.

It is strange that the advocacy and rights agenda for mental health in India has been hitherto conceived and executed by medical professionals only. These efforts have not bothered to even try to incorporate voices from the community of active or ex-users of these services. They have not recognised the conflict of interest or the morality in speaking for a community, which is not, and has never been, adequately represented in their political platforms. This blatant paternalism towards the patient community has to be questioned and

rejected outright. It is this paternalism that allows practising professionals to violate ethical protocols of consent and patient participation in treatment.

The Available Statutes and Instruments

The Indian Lunacy Act (ILA, 1912) was changed to the Mental Health Act (MHA, 1987) and implemented in 1993. The Persons with Disabilities Act, (PWDA, 1995), has also been effected and the disability movement has made some minor gains by working this act in its own interest. The PWDA promises non-discrimination and equal opportunities for persons with disabilities. The category of 'mental illness' is included in the PWDA, though there have been problems on multiple fronts in utilising this statute for persons with psychiatric disabilities. The community of psychiatric users and survivors has not yet made the conceptual linkages or political alliances with the disability movement. It has taken a while to wake up to the fact that psychiatric disability needs to be operationalised and quantified for governments to enable policy implementation. So while 'mental illness' is included as a disability on paper, none of the rights and benefits that could accrue on this count has been forthcoming from the state. In some professional circles (Schizophrenia Research Foundation, 2000) advocacy efforts are on in order to assist the government in operationalising psychiatric disability. But once again, these efforts have been purely professional and have not attended to the larger concerns of the user community.

The MHA does not have a Rights chapter, being, in letter and spirit, only a minimalist custody Act. It is about institutional admission and discharge. Dhanda (through 1984-2000) has extensively analysed the limitations of the MHA and has argued for a maximalist law, which will bring in the rights regime. Among its many problems, Dhanda has noted the following:

- (a) The definition of the mentally ill within the law is narrower than the scientific definition and is ambiguous, confusing and ad hoc.

- (b) Leaving the right of incarceration to relatives places too much trust in the goodwill of relatives.
- (c) The lack of a Rights chapter indicates the lack of state interest in the quality of lives and personal liberties of the mentally ill.
- (d) Even gross instances of institutional and professional abuse have not invited appropriate justice.
- (e) Those diagnosed with mental illness in law are not considered legitimate persons/citizens, being deprived of civil liberties (such as right to contract, own property, etc.) and state protection.

The MHA, by simply giving the norms of institutionalisation (admission and discharge) exists only to protect the interests of the courts, the state and society, and not the interests of the mentally disabled. As it stands, the MHA is an extension of state's power for taking inconvenient individuals into custody, viewing them as a 'law and order' problem. Dhanda has emphasised that, against this scenario, bringing mentally distressed women within the purview of law in any context is a problem. Instead of empowering them, the law is likely to further disempower and stigmatise them.

Other international instruments granting rights to persons with a psychiatric diagnosis include the United Nations Principles for the Rights of the Mentally Ill, the Standard Rules for Disabilities of the UN, the 10 Basic Principles of the World Health Organisation, etc. Such instruments are also consistent with others such as the CEDAW and the Universal Declaration of Human Rights. These instruments are mostly about giving good quality care and equal opportunities for persons with mental disabilities. While not being regulatory, they do encourage governments to provide the social context for non-discrimination and equal opportunities. Especially promised in these instruments is the right of the psychiatrically diagnosed person not to be discriminated against for being a woman.

Two major concerns among advocates for rights of persons with a psychiatric disability have been *a*) the lack of legislation in the area of public health giving health (and mental health) related rights; and *b*) the very insensitive legislation taking away nearly every single

civil liberty of such persons. So even if equal opportunities laws for such persons are extant, they are totally contradictory to the highly discriminatory and exclusionist civil statutes regulating marriage, family, employment, management of assets and property, holding public office, voting, etc. In every one of these laws, 'unsoundness of mind' excludes participation in civil society to some degree or the other.

Among NGOs and advocacy groups there has been a resurgence of critical interest in these statutes (Workshop 2001). As more and more community-based organisations encounter mental health problems in their work, the domain of law reform and advocacy in mental health becomes of paramount importance. While alliances must be made with health activism in pressing for user-empowering public health legislation, the speciality of the mental health domain also needs to be taken into account.

From the policy side, there is the National Mental Health Programme (NMHP), 1982. This document shifts the basis of practice from the traditional (psychiatric) services to community care. The NMHP is only a footnote to the national health policy, and does not offer any (fiscal or technical) supports for building community initiatives, and simultaneously leading to the downsizing of already existing facilities. Further, the priorities of NMHP (psychoses, epilepsy, psychoneuroses — in that order) are such that interventions involve nothing more engaging or humane than drug dispensing. While in its philosophy, the policy signals 'revolutionary' ideas in community care, in practice, and by the way that priorities are set up, the bio-medical model is reinstated, that too in its least rigorous and most problematic form, i.e., through the primary health care (PHC) centres.

A major objective of Community Mental Health care in India is 'training' and creation of a cadre of non-medical professionals in mental health (non-governmental organisations, social workers, community health-workers, etc.). It was believed in the 1980s that the existing (*sic.*) PHC system would, through training, be able to accommodate mental health as well; so extra finances or other resources need not be invested by the state. The psychiatric

community also did not see any problems in 'training' all and sundry in making psychiatric diagnosis in the community. Voluntary initiatives bringing in more and more NGOs into the mental health arena are recent, and the questions relating to this phenomenal growth vis-à-vis state inactivity needs to be explored.

Both the NMHP and the MHA limit themselves to those diagnosed with severe illness. The reason for this is that, a psychiatric diagnosis, especially of the severe type, and criminality are close in terms of legal conceptualisation, and both are brought to the forefront when law and order is at issue. The state has repeatedly exhibited paternalism towards the mentally ill – as is evident in the politics of institutional care, especially for women. The defence in the case of hysterectomies in Sirur was built upon feudal notions of social (parental) burden in protecting the girl child's body/sexuality. The so-called 'societal burden' for the mentally ill is also said to be more acute in the case of severe illness. In recent years this paternalistic argument has become stronger, leading to the formation of very vocal 'parents' groups', which renders the autonomy of the person with psychiatric diagnosis even more compromised at the societal level. These groups call themselves 'consumers' while the end-user of treatment, on whom things are actually done, is still silent.

Advocates have emphasised that both law and policy, as they exist now in India, serve only to protect the interests of the state, courts, family and society, rather than the interests of persons who have entered the psychiatric regime. At the societal level, these instruments maintain the cultural imperatives and paternalism. Dhanda (2000) is probably the most comprehensive database on how communities and families deal with persons, especially women, with a psychiatric diagnosis. Social reasons for incarceration of women within mental hospitals are also against the women's interests. Women who deviate from the feminine role (good wife, chaste mother, dutiful daughter-in-law), infertile women, women from whom economic benefits are sought to be extracted, and women who stood in the way of the husband's second marriage, have all been trapped in insanity petitions for divorce. Thus, the available legal and policy instruments facilitate

social control over individual behaviour and, through the family and other civil society institutions, maintain the state prerogative to take behavioural deviance into custody, rather than facilitating adequate, appropriate or humane interventions for people in distress.

Agendas for Activism

The following are some agendas that call for activism and can be used as platforms. First, with respect to women in mental institutions, the state needs to

- 1) provide transparent, humane, appropriate and open treatments in mental hospitals and other state supported in-patient facilities;
- 2) effectively implement the available statutes, procedures, systems and norms to ensure the above;²
- 3) enable patient involvement in in-patient facilities by changing the constitution of the Board of Visitors to include users/user groups, instituting patient councils, or through some other mechanism;
- 4) install non-paternalistic institutional processes for women;
- 5) create gender-sensitive cross-referral systems in institutional care;
- 6) implement the mandatory rehabilitation programmes in a gender-sensitive way;
- 7) provide vocational training, social security and legal and institutional supports for deserted, homeless mentally ill women who are institutionalised or jailed.

The process of certification, which often involves a notorious nexus between the police, the magistracy, the families and the professionals, must be thoroughly evaluated and streamlined against infringement of rights. Second, with respect to psychiatric treatment there is the need to press for processes and procedures ensuring free participation in treatment. Involving user-participation in the design, process and evaluation of every type of treatment or service being offered for

mental disorder is legally mandatory in the West. Involuntary care should be clearly delimited by law and should not be given such an all-encompassing place in care and treatment. Isolation rooms and physical restraints in in-patient facilities should be phased out and banned.

We must pressure for the formulation of stringent controls on the use of ECT, including specifying rational use, humane methods, treatment guidelines, consent, proper documentation and right to information. Preceding ECT treatment, patients should be informed about risks, alternatives, a detailed description of the procedure until the patient understands, and the option to say no. The use of ECT needs to be governed by an explicit law. A precise legal definition of 'extreme cases' when ECT will be used *per force* must be specified. The authorities must upgrade technology and personnel training for giving ECT in all hospitals.³ Scrupulous records must be maintained regarding every ECT use, including profile of patient, diagnostic details, reason for use, patient acceptance, side effects and follow-up. Such records should be made available to the patient on demand. A national-level debate is necessary for evaluation and policy-making on the rational use of anti-psychotic, anti-depressant and other drug prescriptions for mental disorders.

Thirdly, a good, community-oriented policy should not limit itself to just a drug dispensing medical programme. Community care should be provided as planned care based in the community, taking into account local social needs, housing and empowerment problems, conflict areas, etc. The PWDA has some potential required for basing mental health work at the community level. Through the disability programmes, the state should support (technically as well as economically) the establishment of community initiatives and self-help groups for women who are mentally ill. Rehabilitation, sheltered workshops, and other employment, social welfare schemes and concessions that are extended to disability groups, must be extended to those with a psychiatric disability also. The state must spend more in creating educational and training institutions that focus more on psychotherapy, psychiatric nursing and counselling.

Fourthly, there is a need for debating the issue of professional regulation in mental health, as 'self-regulation' does not seem to be working in the interest of the mental health of patients. While acknowledging the business-like nature of contemporary psychiatric practise, the trade rules and what constitutes the standard of good quality care in mental health are not very explicit. The advocacy movement for mental health in India has been demanding, albeit with little success, only this much from the professional community: 'If you are in business, at least tell us what your rules are and what you will term as bad trade.' This courtesy, which one usually gets even from our *kiranawalas*, has not been forthcoming from the professionals!

Finally, from the women's point of view, there is a need for monitoring and evaluation of the sexual ethics of professional practice. In the West, the American Psychiatric Association in 1973 proscribed professionals from *a*) fostering traditional sex roles, *b*) having biased expectations of clients, *c*) using psychoanalysis in a sexist way, and *c*) responding to clients as sex objects (Holroyd 1983). Ethical codes for practice will enforce attitude changes in the mental health profession.

Ethical Dilemmas in the Women's Mental Health Movement

Activists pressuring professionals to state their moralistic position on 'gender' learn soon enough that they first need to ask themselves about their own morality in dealing with psychiatrically diagnosed women. Many ethical dilemmas confront NGOs and collectives working in mental health from the platform of 'women' or 'gender'. That there are tensions between women's group interests and user group interests is evident from the following remark made by Judi Chamberlin, a well-known mental health activist. She protested that feminist interventions in general are 'a deliberate slap in the face of thousands of psychiatric survivors who continue to struggle for freedom and independence against the full power of both

the psychiatric establishment and the new feminist therapy establishment' (1994).

For example, as a way of marking inclusion, diagnosed women are specifically invited to the agenda-setting meetings on women's mental health. These women, suddenly exposed to a whole range of issues that they were experiencing in a very personal way on a day-to-day basis, are made vulnerable in the meetings. Their privacy is sometimes threatened because their participation in debates often means making their distress, and the consequences of that, public. Support systems and safety nets are unavailable to handle concrete situations of women's distress. Being invited to a meeting because you have had a diagnosis of severe mental illness requires some getting used to, given the stigmatising context within which mental illness is dealt with in Indian society. The stress on collectivism also demands the ability to speak on one's own behalf and on behalf of the diagnosed community. Even if not forced to speak, there is the unsaid expectation that they should use the opportunity created on their behalf and willingly speak up. In large meetings, there is little control on interpersonal and emotional responses to diagnosed women, and an insensitive remark, 'thinking aloud', or misrepresentation can be anti-therapeutic. Disclosures in order to be therapeutic need to happen in safe, structured and rehearsed environments, and meetings do not necessarily always offer that environment. There have been situations of breakdown during or after the meetings, and some of us have felt guilty and anxious at not having foreseen this sooner.

Diagnostic concepts such as 'depression' and 'anxiety' should not be freely used within NGO work in mental health. With a psychiatric diagnosis, Indian law withdraws nearly all civil liberties, without giving adequate legal cover for good care and treatment. If psychiatric diagnoses were to be loosely documented within organisations, the woman's interests would be compromised if her case goes to court. This, in fact, is more than a likely possibility with every case of violence or divorce, where the woman is in obvious distress or even receiving treatment. Women's counselling centres would

de-emphasise diagnosis, use mainstream systems, if at all, for diagnosis, but create self help alternatives and strengthen their own social and legal advocacy base in mental health. They would evolve some protocols for the documentation and use of information about women's psychiatric problems, especially in preparing or giving 'evidence'; in fact, they would not give this privileged information as evidence in court.

Women with a psychiatric diagnosis do not necessarily have a political or advocacy agenda either about women or about mental health, and to force it on them is problematic. The 'emancipation' trick will not necessarily work in relieving distress and it cannot be overplayed in healing contexts. Direct involvement of diagnosed persons in the women's movement would have to be negotiated openly, fairly and in the interest of the diagnosed women. If this is not possible, it is better not to involve or be involved with the women. Some advocates have resolved that they will negotiate only systemic issues and not have person-to-person negotiations with diagnosed women when there is an inability to provide healing environments, safety nets or therapeutic support.⁴ In making an 'agenda' of mental health, women not directly involved with the movement, but who have been diagnosed or are distressed, inevitably approach the organisation seeking help. Organisations need to create knowledge and support systems before they expand their area of work into mental health.

Feminist advocates in mental health may take the position that 'ECT is wrong' or 'anti-psychotics are hazardous'. Whether anyone can take psychoactive drugs or not can be debated at the abstract level, but to advise someone whether she should continue with her Clozapine prescription or whether she has been over-prescribed, requires other types of information and advocacy skills. These need to be cultivated. The movement's emphasis on experience sharing, oral histories and alternative methodologies entails that privacy is not an acceptable value. However, in an active engagement with psychiatrically diagnosed women, making personal distress a matter of public narrative poses clear problems. The staff of the organisation

may not be sensitive and may inadvertently reinforce stigma. A diagnosed woman within the movement is still woman marked by the stigmatising discourse within which 'mental illness' is understood by society. Organisations need to provide her with adequate private space so that she feels safe and protected by the movement. Because group pressures may work within the overall political context of feminism with its multiple agendas, the women's own story of mental illness may not have a shared universe of articulation. For example, if the discussion around diagnosis is a wholesale rejection of 'mental illness' (as a form of protest or as a metaphor), diagnosed women may in fact experience anxiety and insecurity. It has been noted that a radical anti-psychiatric position that mental illness is just a convenient, moneymaking construct made by some unscrupulous male professionals, is *not* favoured by those who have been psychiatrically diagnosed. When experiences and behaviours are beyond the perceptible control of what they see as their 'selves', and the social world has broken down, the diagnosis gives them a site to root their identity. And who is to say that this is not a legitimate way of orienting oneself to the world? For people in subjective distress, naming the distress may reduce their anxiety and fears, increase their hope of a 'cure' and enable them to think that they can 'do' something about it.

Today, women's groups and NGOs are organised political groups, working civil society mechanisms to their own interest. Eminent spokespersons for women's rights are influential people at the highest levels of negotiations with the mainstream at a global level. Those with a diagnosis of mental illness are an unorganised community, living largely without political, legal or social support systems and having little power to negotiate the instruments of civil society. While women's organisations can be seen as the most effective agency for community mental health and mental health advocacy, this acknowledgement comes with a rider about seriously addressing these questions. From the platform of a community of psychiatric users and survivors, the women's movement is a *third* party, and

that negotiating distance must be respected.

Conclusion

As more and more NGOs and women's organisations move into the mental health arena, new concepts are being brought into the movement's vocabulary, including 'depression', 'Obsessive Compulsive Disorder', 'anxiety' and 'stress', which did not exist before. Even though this language may carry critical content, there is the fear that it may also bring in a much-resisted empiricism and medicalisation that was not there before. Certainly, there is the foreseeable danger that with more women being now aware of the mental health vocabulary, a larger 'market' is opened out to private practitioners and to the drug companies. Does the women's movement have ways and means of branching out into other critical areas where advocacy is much required? There is also the risk, already evident in the Western mental health scenario, of generating a whole range of community services for 'being-wellness' while ignoring the hard problems of the chronically mentally ill or of the linkages between poverty, criminality and mental illness. A middle-class consciousness, which has in fact led to present-day concerns about women's mental health in India, is very dominant and its limitations must be understood. Not all the implications of 'making a feminist agenda' of mental health have been fully examined. A body of critical literature, setting up a hermeneutic dialogue between various feminist voices, is yet to evolve.

Notes

- 1 An earlier version of this paper was presented to the WAH! Advocacy Seminar in New Delhi. I thank Dr Amita Dhanda, who has been an important source for this paper, for making the presentation at this forum. Versions of this paper have been presented in other forums through 1999-2001, the IFSHA Seminar on 'Ethical issues in feminist research'; 'Women and mental health — Planning for gender sensitive community mental health' organised by Bapu Trust, Pune; 'Women and mental health' organised by Aalochana, Pune; 'Facilitating legal activism- Law and mental health', organised by

Bapu Trust, Pune. Some parts of it are also drawn from my Homi Bhabha Report on 'Concepts and practices in community mental health – A primer in philosophy and social criticism for mental health professionals'. I thank the Homi Bhabha Fellowship Council for supporting my work through 1999-2001.

- 2 For example, in Maharashtra, even though the State Mental Health Authority was constituted long ago, they did not meet for over three years!! The Bombay High Court made 68 recommendations for the reform of Yerawada Mental Hospital, Pune, through the Mahajan Committee in the early 1980s. It is anybody's guess whether and how this has been implemented.
- 3 Most of the hospitals still use outdated machines and give direct ECT, which is very dangerous. In some hospitals, patients line up outside the room and the ECT is given on a bare wooden plank, with the other patients watching!!
- 4 Amita Dhanda in a recent workshop has reiterated her oft-repeated caution that instead of involving persons with a psychiatric diagnosis in court cases, and revictimising them, it may be better to address the statutes and press for changes there. Absent, a user movement in mental health, a social justice platform seems the only feasible option.

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*Chapter 31***Violence against Women
A Health Issue**

Renu Khanna and Yamini Venkatachalam

Violence against women, often known as ‘gender-based’ violence, refers to many types of harmful behaviour directed at women and girls because of their sex. This includes physical, sexual, psychological abuse within the family and the community. Domestic violence is defined as physical, emotional or economic abuse of women, either by their husbands or other members of the family within the home. Violence against women encompasses spousal battering, sexual abuse of female children, dowry-related violence, rape — including marital rape — and traditional practices harmful to women, such as female genital mutilation and female infanticide and foeticide. It also includes non-spousal violence, sexual harassment and intimidation at work and in school, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state, such as rape in war (Article 2, UN Declaration on the Elimination of Violence Against Women, 1993; Population Reports 1999).

Violence against women has its roots in unequal societal structures and is further exacerbated by increasing social and economic

inequalities. For example, the changing economic situation in the country has resulted in women being subjected to intense deprivation and disabilities and has also contributed to an increase in crimes against women inflicted by society. These crimes manifest themselves in terms of dowry harassment, abetting prostitution, the sale of girls, etc. State-level policies have affected the country's cottage industries and the agrarian sector. Due to economic distress in these sectors, the working class, including women, is forced to migrate to cities, unprepared and unprotected. Migrant women have little or no access to health care in the cities. Being daily wage earners, it is difficult for them to access the larger hospitals and private medical practitioners (Mahindroo 1999).

Magnitude of the Problem

Violence against women is a global problem. In countries like India, where boys are valued more than girls, the life cycle of violence starts with sex-selective foeticide and infanticide. During infancy, girls may be frequently discriminated against in terms of allocation of resources, such as food, health care and education. Approximately 60 million women, mostly in Asia, are 'missing' – killed through infanticide, selective abortion, deliberate under-nutrition or lack of access to health care (Panos 1998; UNFPA 2000; Spindel et al. 2000). From girlhood to adulthood, women continue to be at risk. According to WHO, one out of every five women is a victim of rape or attempted rape in her lifetime (WHO 1997; Spindel et al. 2000). Each year, thousands of women and girls are trafficked and forced into prostitution. Evidence from nearly 50 population-based studies throughout the world shows that 10 to 50 per cent of women have experienced domestic violence, have been hit or otherwise physically harmed by an intimate partner (Population Reports 1999). This makes it the most prevalent form of gender-based violence, followed by sexual violence. Between 12 to 25 per cent of women have experienced forced sex by an intimate partner or ex-partner at some time in their lives (WHO 2000a).

The National Family Health Survey (1998-99), NFHS 2, found that at least one in five women have experienced beatings or physical mistreatment since age 15, and at least one in nine had experienced such violence in the 12 months preceding the survey. Most of these women have been beaten or physically mistreated by their husbands. Domestic violence against women is especially prevalent (27 to 29 per cent) among women working for cash, poor women, scheduled caste women and widowed, divorced or deserted women. The NFHS 2 has also found a high level of acceptance of domestic violence among women. More than half (56 per cent) of the women accept at least one of six reasons as justification for a husband beating his wife.¹

Evidence from small population-based studies shows a high prevalence of violence (Table 31.1). A study of the records in the Emergency Police Register of the Casualty Department in a public hospital in Mumbai revealed that 23 per cent of the women who were brought into the Casualty were definite cases of domestic violence. They had suffered assault by a family member or a 'known person'. Another 44 per cent of all women appeared to be possible victims of violence. However, they either refused to name the perpetrator of the assault (19 per cent) or attributed the burns that they suffered to accidental stove burst (9 per cent), or were cases of attempted suicide — a measure that most women who suffer violence and harassment are likely to resort to (16 per cent). Thus, up to two-thirds of women reporting to the casualty department may have suffered domestic violence (Daga et al. 1998). Interviews with patients, following observations of client provider communication in a Gynaecology outpatient department (OPD) indicate that there are incidences of domestic violence that go unquestioned and unreported even within the hospital situation (WCHP 2001).

Violence against women considerably increases women's risk of poor health. According to the World Bank (1993), rape and domestic violence account for 5 per cent of the healthy years of life lost to women aged between 15 and 44 in developing countries. Worldwide, gender-based violence accounts for more death and ill health than cancer, traffic injuries and malaria put together.

Table 31.1
Prevalence of Domestic Violence in India

<i>Author(s)</i>	<i>Sample</i>	<i>Findings</i>
Visaria (1999)*	346 currently married women with at least one child less than three years of age.	65% reported some form of psychological, physical or sexual abuse; 42% experienced physical beatings or sexual assault; 23% suffered abusive language, belittlement and threats.
Jeejeebhoy (1998)	1,842 women aged 15-39 years from two districts each of Uttar Pradesh & Tamil Nadu.	42-48% prevalence reported in Uttar Pradesh, 36-38% in Tamil Nadu.
Rao (1997)	177 women of child bearing age and 130 men in three villages, potter community.	22% of women were physically assaulted; 34% of those physically assaulted required medical attention.
Narayana (1996)	6,926 married men from five districts of Uttar Pradesh.	30% of men reported beating their wives.
Ganatra (1996)	400 villages in Maharashtra (population 686,000) and seven hospitals.	15.7% of pregnancy-related deaths in the community series and 12.9% in the hospital series were associated with domestic violence.
Mahajan and Madhurima (1995)	115 women from lower caste households in Punjab.	76% prevalence, two-thirds of whom reported regular beating.
Bhattacharya and Pratinidhi (1994)	42 childless married women aged 14-45 years, urban slum community.	19% were physically assaulted because they were childless.
Seshu and Bhosale (1990)	120 cases of dowry deaths and 20 cases of intentional injury related to dowry identified in 50 district court judgments, 1987-1989, Maharashtra.	Intentional injury included physical violence (59%), mental torture (28%), molestation by family members, perversity (10%), and starving (3%). Causes of death in women who died: burns (46%) and drowning (34%); 58% of the victims were childless and 22% had only female children.
Mahajan (1990)	109 women and men from one village, scheduled caste and non-scheduled caste.	75% of scheduled caste wives reported being beaten, 75% of schedule caste men and 22% of other caste men reported beating their wives.

Source: WHO. 2000. *Women of South-East Asia: A Health Profile*, New Delhi: WHO.

* Visaria, Leela. 1999. *Domestic Violence in India: Evidence from Rural Gujarat*, Washington D.C.: ICRW.

The health consequences of violence range from non-fatal outcomes that have impact on physical and mental health, to fatal outcomes like suicide, homicide, maternal death and HIV/AIDS. Among the physical health consequences are injury (lacerations, fractures and internal organ injuries), unwanted pregnancy, gynaecological problems, STDs including HIV, miscarriage, pelvic inflammatory disease, chronic pelvic pain, headaches, permanent disabilities, asthma, irritable bowel syndrome, and self-injurious behaviour like smoking and unprotected sex. The mental health outcomes are depression, fear, anxiety, low self-esteem, sexual dysfunction, eating disorders, obsessive-compulsive disorder and post-traumatic stress disorder. Violence against women is thus a major public health concern and should be a priority for the health sector because it causes immense suffering and negative health consequences for a significant proportion of the female population. The costs of violence against women are tremendous, not only for the individual but also for society in terms of providing medical care and legal services (Heise et al. 1994).

Role of the Health Sector

The health care system and health-workers are in a unique position to identify, document and respond or refer victims of violence, because they are the first contact point for persons who have been assaulted, as they do seek medical assistance for their injuries even if they do not disclose the violent incident. The health care providers can provide comprehensive, gender-sensitive health services to victims of violence to manage the physical and mental health consequences of the assault.

Health care providers, however, generally seem to believe that the causes of physical injuries that battered women present are not their business. They perceive their role as limited to dressing the wounds and prescribing medicines. Some view domestic violence as a private issue and fear that clients would be upset or offended if asked directly about violence. Others do not quite know how to ask and how to respond if a woman does admit to being abused. Yet others feel that

they have no time or space (within the context of overcrowded dispensaries and out-patient departments) to deal with the needs of victims of violence.

Another barrier that prevents health-workers from addressing violence is that they belong to the same cultural and social milieu as their patients. They share the same values and attitudes towards abuse that are prevalent in the larger societal context. For instance, many women and men believe that a woman is the property of her husband and so an occasional beating is quite acceptable. The constructs of sexuality in many cultures define that women have to be available for sex whenever their husbands need it (Khanna and Verma 2000). Male clinicians may hesitate to accept a woman's account of violence because they identify with the offender. Female health-workers who have been victims of abuse may not find it easy to discuss violence with their patients.

Another major barrier is the reluctance of doctors to get involved in legal liabilities and procedures. Lack of referral services and poor coordination between health, legal and social welfare departments also act as deterrents (Khanna and Verma 2000). Studies show that women who have been battered value direct questions about abuse, referrals to appropriate agencies that offer assistance, follow-up visit. Box 31.1 presents a list of what 155 battered women in Wisconsin, USA, considered as supportive behaviour in the context of health providers.

Though health care providers can do much to help clients who are victims of gender-based violence, they often miss opportunities to do this because they are unaware, indifferent or judgemental (Population Reports 1999). With training and support from health care systems, providers can respond more positively to the physical, emotional and security needs of abused women and girls. They can learn how to ask women about violence in ways that the women find helpful. They can give women empathy and support. They can provide medical treatment, offer counselling, document injuries, and refer their clients to legal assistance and supportive services. They can reassure women that violence is unacceptable and that no woman

Box 31.1**What Women Consider Supportive Behaviour in Health Providers****Medical support**

- Taking a complete history
- Detailed assessment of current and past violence
- Gentle physical examination
- Treatment of all injuries

Emotional support

- Confidentiality
- Directing the partner to leave the examination room
- Listening carefully
- Reassuring the woman that abuse is not her fault and validating her feelings of shame anger, fear and depression

Practical Support

- Telling the patient that spouse-abuse is illegal
- Providing information and telephone numbers for local resources such as shelters, support groups, legal services
- Asking about children's safety
- Helping the patient begin safety planning
- Scheduling a follow up visit.

Source: *Women of South-East Asia: A Health Profile*, WHO, 2000b, New Delhi

deserves to be beaten, sexually abused or made to suffer emotionally. Family planning and other reproductive health care providers have a particular responsibility to help because abuse has a major, although little recognised, impact on women's reproductive health and sexual well being. Unless they understand how violence and powerlessness affect women's reproductive health and decision-making ability, the services they provide will not be effective (WHO 1997).

State Interventions

The Government of India has taken many punitive measures to deal with various forms of violence like rape² and sexual assault, dowry and cruelty to women in matrimonial homes,³ and female foeticide⁴ (Box 31.2). It now proposes to criminalise domestic violence.⁵ In addition to these existing laws, there have been various state

Box 31.2**Laws on Various Forms of Violence against Women****Rape and sexual assault**

- Section 375 IPC - unlawful sexual intercourse by a man with his own wife under the age of 15 years; with any other woman under the age of 16 years with or without her consent; with any other woman above the age of 16 years against her will, without her consent.
- Section 376 A - sexual intercourse by a man with his wife without her consent or against her will at a time when there exists a legal separation.
- Section 376 B, C, and D, IPC - sexual intercourse by a male public servant; by male superintendent or a manager of a jail or other place of custody; by a man on the management of a hospital or a nursing home, with a woman in his custody or in the precincts of the hospital.
- Section 354 IPC - assault or use of criminal force to outrage a woman's modesty.
- Section 509 IPC - violation of a woman's modesty by word or gesture.
- Section 511 IPC - attempt to rape.

Domestic violence

- Section 498 A, IPC - cruelty to a woman within the matrimonial home.
- Dowry Prohibition Act 1961
- Commission of Sati (Prevention) Act 1987

Female foeticide

- The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994

interventions to make legal services more accessible to women experiencing violence and abuse. These include legal aid cells, family courts, *Lok Adalats* or people's courts, and *Mahila Lok Adalats* or women's courts. All-Women Police Stations, police counselling cells, community policing initiatives, and special cells run by NGOs at police stations have also sought to address the different needs of women experiencing abuse. (Mitra 1999; Poonacha and Pande 1999).

All-Women Police Stations (AWPS)

Attempts to make the police more accessible to women have taken the form of All-Women Police Stations (AWPS) (or *Mahila Police Thanas*) and India is perhaps one of the few countries where such an effort has been made systematically. These AWPS are now generally responsible for cases involving domestic violence, dowry-related offenses, sexual harassment, trafficking of women and children, rape

and other crimes against women. The response usually takes the form of such procedures as filing a complaint, trying to resolve the issue with the accused through counselling or mediation, or sending the case to court. However, case studies of the AWPS in Madhya Pradesh, Maharashtra, Karnataka and Gujarat show that these stations suffer from several inadequacies. Several vacancies have not been filled and they are poorly supplied in terms of vehicles, equipment, toilet facilities, running water supply and clean restrooms. The stations also do not offer any health services for women in need of medical attention. Moreover, since there is the pressure to register all complaints pertaining to women at the AWPS (police in Bangalore and Ahmedabad have transferred the jurisdiction of sex-related crimes to the AWPS), women are generally discouraged from registering complaints elsewhere. Thus women victims of violence are forced to travel great distances to register their complaints with the AWPS. This only creates more problems for women who may be unable to travel long distances and are deprived of speedy protection from the police in their neighbourhood (Mitra 1999; Poonacha and Pande 1999).

Family Counselling Cells

Another response to domestic violence is the Family Counselling Cell (FCC) or unit. The objective behind setting up these cells was to help strengthen and improve family ties with the help of community intervention and thus avoid legal prosecution. FCC units are also run by non-governmental organisations. The national Central Social Welfare Board (CSWB) initiated a nation-wide effort to fund these cells in and around police stations and among a network of voluntary organisations in response to perceived increases in family- and marriage-related crimes and disputes. Overseen by state-level Voluntary Action Boards (VABs), the official mandate of the cells is to facilitate reconciliation and an amicable settlement before undertaking any legal action, and to support and maintain the family unit for the sake of the children. Centres are supposed to provide preventive, referral, and rehabilitative services to the victims of domestic violence and what is termed 'marital maladjustment'. Case

studies show that the FCC scheme has no standard or universal approach or practice; there are differences between state and NGO practices, and even among cells run by NGOs. Therefore, the character and quality of FCC services can vary dramatically (Poonacha and Pande 1999).

Shelters and Short-Stay Homes

The provision of alternate shelter through short-stay homes, often in partnership with the voluntary sector, has been another response of the state to domestic violence. However, studies have highlighted that all is not well in the functioning of these homes. In seven of the shelter homes surveyed during a study in Madhya Pradesh, only 112 women accessed shelter services despite a combined capacity for 370 residents (Mitra 1999). Government-run shelter homes restrict the mobility of residents and also the number and age of the dependents of the residents. Further, recreation facilities and infrastructure are often lacking. The ambience of these short-stay homes is typically one of strict policing and hardly conducive to recovery from the emotional trauma that women experience with an abusive partner. Apart from an initial, mandatory health check-up to rule out diseases, barring emergencies, women cannot go to even a civil hospital for health problems because of lack of transport and strict rules surrounding mobility. Services for the mentally ill have also been found to be poor (Poonacha and Pande 1999).

Other interventions within the judiciary like *Lok Adalats* and *Mahila Lok Adalats* (Women's Courts) function primarily as conciliatory mechanisms. They do not have punitive power and therefore rely exclusively on mediation counselling to bring together all the parties involved to reach an understanding. While counselling has its own value in dealing with marital discord, it may not be an adequate response in all instances of violence (Poonacha and Pande 1999).

NGO Interventions

Women's groups and NGOs have played a very important role in bringing up violence against women as a public issue. It is their

activism and protests against dowry deaths, custodial rape, sati, female foeticide, sexual harassment, prostitution and trafficking that have brought about laws and amendments in the country's existing laws to deal with violence. NGOs have come up with many innovative interventions for reaching out to women, be it with legal aid, through counselling centres, or promoting income-generating activities. Some of these interventions are listed below.

Community-based Violence Prevention and Management Programme: MASUM

Established in 1989, the Mahila Sarvangeen Utkarsh Mandal (MASUM) is a Pune-based NGO presently active in 25 villages in the areas of health, sexuality, paralegal work, counselling and income generation for women. MASUM recognises that no intervention would be relevant unless it took a major step in confronting the issue of violence against women. It works through an integrated approach that emphasises the curative, preventive and promotive aspects of preventing violence against women (Rinchin and Samata 2001). The *Streewadi Arogya Kendra* (Feminist Health Centre) and the *Sadaphuli* (Periwinkel) centres, besides being contact points for women experiencing domestic violence, also carry out health education and management of illnesses using traditional and indigenous recipes. Women are trained in self-examination and self-help in managing their health problems. The *Streedhan* (women's resource) is a credit and savings programme for women to promote economic independence and reduce indebtedness. MASUM also has vocational training and health education programmes for young women. *Samvad* (Dialogue) is a counselling and legal aid centre for women facing violence. From village-based legal first aid centres called *Saathi* (colleague or comrade) paralegal workers provide legal first aid and create community awareness related to rights and laws. These outreach centres help people file FIRs, inform them of their rights vis-à-vis the police, and try to restore posthumous rights to the victims of violence. It also engages in preventive work such as registering all marriages to deter men from committing bigamy later on. Pressure groups are formed within the community to challenge

prevalent norms that foster violence. Women are also being organised to form support groups and provide temporary shelter to women facing violence. As part of its promotive activities, MASUM has started working with children and adolescents to inculcate in them the values of social justice, gender equality and non-violence. At the block level, counselling and therapeutic services are being provided to women and children facing violence (Gupte undated).

Gender Sensitisation of the Judiciary: Sakshi

Sakshi, a feminist NGO based in New Delhi focuses, on sexual violence and women's rights. Crisis counselling and legal redress are the main interventions provided by Sakshi (Purewal 1999). One of the innovative initiatives has been its 'Gender and Judges' programme. The objective of this initiative is to establish collaboration between judges and NGOs to introduce gender equality into the legal system. The inspiration came from Sakshi's experience in working with female litigants and its observations of gender bias in the judiciary.⁶ The first step was the organisation of a meeting of superior court judges, lawyers and activists from the Asia Pacific region to discuss gender bias in the courtroom. The meeting resulted in the Asia-Pacific Advisory Forum on Judicial Education on Equality Issues, a partnership between judiciaries and NGOs. The Forum has begun a process of gender equality education throughout South Asia. Under Sakshi's guidance, judges are being trained to teach their peers about gender equality, and Sakshi plans to include the police and health care practitioners in the education programme. Sakshi would like to see law schools and judicial training institutes incorporate gender equality education into their curricula. Sakshi has successfully used the concept of equality as an entry point for getting the judiciary to address gender-based violence (Spindel et al. 2000).

Sexual Assault Kit: CEHAT

All-India statistics show that successful conviction of the accused happens in less than 30 per cent of the registered cases of rape. Though it is difficult to pinpoint the causes for the low rate of conviction in cases of rape, the role of medico-legal evidence and

experienced medical witnesses is considered most significant, because many of the essential ingredients of rape cannot be proved or disproved without medical evidence. However, many qualified physicians, especially in smaller towns and villages, lack the specialised training required to proceed with this sort of medical examination or how to handle appearances in court. It is possible for a case to be lost, not for lack of actual evidence but for the inexperience of the medical witness. Therefore, to build the capacity of examining physicians in collecting medical and forensic evidence, the Centre for Enquiry into Health and Allied Themes (CEHAT) has prepared a manual and evidence kit. This kit is meant for the medico-legal examination of any sex-related crime. It contains guidelines for the physician's record of both the medical history and detailed account of the history of sexual assault. In addition, advice is given on the procedure for conducting general examination and collecting forensic material and the treatment of physical and psychological conditions that result from the assault (D'Souza 1998).

One-stop Crisis Centre: DILAASA

Dilaasa is a project situated within the K.R. Bhabha Hospital in Bandra, Mumbai. The project is a partnership between CEHAT and the Brihanmumbai Municipal Corporation and is supported by the Ford Foundation. It is aimed at setting up mechanisms to identify women who come to the public hospital and are victims of domestic violence and to provide them with comprehensive services. These services include treatment of injuries, counselling, providing temporary shelter if needed, referral services to other shelters in the city or rehabilitation agencies, legal aid groups, and so on. The project activities include research and documentation, sensitisation and training of health care providers around issues of gender-based violence, screening of women to identify victims of violence, counselling skills, and ethical and sensitive treatment modalities.

Conclusion

There is still a long way to go in terms of interventions that will

deter violence against women and provide support services for women affected by violence. Recognition of gender violence as a health issue and documenting its prevalence and health consequences, providing special care for women seeking medical help following an episode of violence, including counselling and referral to other support services, and sensitisation of health care providers, such as emergency room doctors, nurses and other staff who are gatekeepers of the health care system for women experiencing violence, are some of the urgent tasks that the health sector needs to tackle. For this, it will have to work in coordination with other sectors like the police, judiciary and the social welfare department.

Health-workers alone cannot transform the cultural, social and legal environment that gives rise to and condones widespread violence against women. Ending physical and sexual violence requires long-term commitment and strategies involving all sections of society. Passing and enforcing laws to ensure women's legal rights and punish abusers are not enough, since gender-based violence has its roots in the subordinate status of women in society. Therefore, community-based strategies should be adopted that focus on empowering women, reach out to men and change beliefs and attitudes that permit abusive behaviour.

Notes

- 1 The reasons include neglecting the house or the children, going out without telling the husband, showing disrespect for the in-laws, husband suspects that she is unfaithful, does not cook food properly, or her family does not give money or other items as expected.
- 2 The Indian Penal Code recognises marital rape only if the wife is less than 15 years of age (Section 375) or she is legally separated from her husband at the time of rape (Section 376 A).
- 3 Besides the Dowry Prohibition Act 1961, Section 498 A, introduced in 1983, makes cruelty to a woman within the matrimonial home punishable with imprisonment up to three years and a fine. It is a cognisable, non-bailable offence, which means that a complaint under this section, once registered as an FIR, would result in the arrest of the members of the matrimonial family of the woman. There is also the Commission of Sati (Prevention) Act 1987, which makes abetment of Sati an offence and has death penalty

as an alternative sentence. Attempt to commit Sati is punishable with imprisonment for a term of up to six months or with fine or both (Ramanathan 2001).

- 4 The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act 1994 prohibits prenatal diagnostic techniques (ultrasound scans and amniocentesis) for the purposes of sex determination. However, modern methods such as the Ericson's technique and the Pre-Implantational Genetic Diagnosis (PGD) can be used to select the sex of the foetus even before conception. Thus the use of these techniques falls out of the purview of the PNDT Act as it is pre-conceptual and not prenatal (Mehta and Kothari, 2001). Recently, the Government of India, Ministry of Health and Family Welfare has proposed an amendment to the PNDT Act called the 'Pre-Conception and Prenatal Sex Selection/Determination (Prohibition and Regulation Act), 2001. Accordingly, emerging technologies for pre-conception sex selection will be included (MOHFW 2001).
- 5 A Bill on Domestic Violence Against Women (Prevention) Bill 2001 has been drafted. It was to be tabled in Parliament in the monsoon session, but will now be taken up during the budget session in February 2002. The proposed legislation makes domestic violence (physical, sexual, verbal, mental and economic abuse) a civil offence and offers right to protection against domestic violence by obtaining protection orders, including monetary relief, custody of children and the right to reside in a shared household. The Bill also proposes to appoint a protection officer or designated persons or institutions that would ensure proper implementation of the court orders. The protection officer would be in charge of coordinating the responses of the police and various service providers such as shelters, hospitals, counselling and rehabilitation centres and legal aid officers (Lawyer's Collective, Women's Rights Initiative, personal communication).
- 6 Sakshi's study of 109 judges showed the extent of gender bias in them. About half felt that women who are abused by their spouses are partly to blame for their situation by virtue of the fact that they stay with their abusers; 68 per cent felt that provocative attire was an invitation to rape and 55 per cent felt that the moral character of the victim is relevant to rape (Spindel et al. 2000).

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*Chapter 32***Laws, Women's Lives and Women's Health**

Padma Seth

Laws are made to regulate social and individual action and behaviour as well as to demand performance and accountability. The law can act as a deterrent, an educative force and, above all, as a leveller. It has the potential to alter power structures in a community, ensure social justice and become an instrument of social change. There are a number of women-related laws in our country, which have mainly evolved for the welfare of women.

The Directive Principles of State Policy of the Indian Constitution speak of a secure social order, welfare of the people, equal justice, free legal aid, village Panchayats, the right to work, protection of health and strength of workers, the right of men and women against exploitation, the right to education and public assistance, maternity relief and protection of the economic interest of deprived classes.

The Constitution of India not only prohibits the state from discriminating against any citizen on the grounds of sex (Article 15), but also at the same time directs it to make special provisions for the well being of women (Article 15[3]). Article 16 deals with

equal opportunity in 'public employment' and Clause 2 of this article specifically mentions women. There are special provisions in the Directive Principles, which enjoin the state to place the two sexes on an equal footing in the economic sphere, by securing to men and women an equal right to work and equal pay for equal work (Article 39, Clauses [a], [b]). To give effect to this mandate of the Constitution, the state has passed, for the welfare of women, a number of laws in every possible sphere like health, occupation, economic security, discrimination, violence and crime. Here we focus on those laws that directly or indirectly affect women's health.

Health-related Laws

Most legislations affecting women's health (see Box 32.1) are either related to their reproductive health — like access to safe abortion — maternal health or occupational health. The Medical Termination of Pregnancy (MTP) Act, 1971, was enacted to curb illegal abortions. It appears that women have a right to choose whether or not to terminate a pregnancy. Under Section 4, abortion can be performed to save the life of the mother. Additionally, abortion is allowed either if the pregnancy is inflicted by rape, or if foetal abnormality is suspected, or if the pregnancy, if continued, would cause mental stress to the woman. Under the MTP Act abortion can be conducted by a trained medical practitioner at a place or hospital approved by the government. Despite the existence of such a liberal law, the number of illegal abortions continues to be high. This is because the law has not been accompanied by systematic efforts on the part of the state to make abortion accessible to women, especially to women in the rural areas, where abortion is a major cause of maternal deaths (Chhabra and Nuna 1994). Though the Seventh Five Year Plan (1985-90) aimed to make abortion services available in *all* Primary Health Centres (PHCs) in the country, less than half the existing PHCs and Block PHCs have been approved by the government to provide these services (CORT 1997).

The Maternity Benefit Act, 1961, provides for leave of no less than

135 days before and after childbirth. However, there are no checks to ensure compliance by contractors and private employers. In many cases, maternity leave is not granted and pregnant women have to give up their employment. Working mothers are neither provided with crèches nor allowed time for breast-feeding. Moreover, in certain factories, unless the woman has worked for 80 to 100 days, she is not entitled to any benefits. Since the majority of women are in the unorganised sector, it is unlikely that they would be continuously retained in any form of employment for that long a period.

Box 32.1

Human Right to Health

The human right to health includes:

- The right to the highest attainable standard of physical and mental health, including reproductive and sexual health.
- The right to equal access to adequate health care and health-related services, regardless of sex, race or other status.
- The right to equitable distribution of food.
- The right of access to safe drinking water and sanitation.
- The right to an adequate standard of living and adequate housing.
- The right to a safe and healthy environment.
- The right to safe and healthy workplace, and to adequate protection for pregnant women in work proven to be harmful to them.
- The right to freedom from discrimination and discriminatory social practices, including female genital mutilation, prenatal gender selection and female infanticide.
- The right to education and access to information relating to health, including reproductive health and family planning, to enable couples and individuals to decide freely and responsibly all matters of reproduction and sexuality.
- The right of the child to an environment appropriate for physical and mental development.

Source: www.pdhre.org, cited in *Advocacy Update*, No. 16, October-December 2001.

Among the occupation-related laws that also cover women's health,

the Factories Act, 1948, provides for separate toilets and resting places for women. It prohibits women from working between 7 p.m. and 6 a.m. and engaging in hazardous work. The Contract Labour (Regulation and Adoption) Act, 1970, also stipulates for separate rest rooms for women and crèches and playgrounds for children, but these are rarely provided and violators go unpunished.

Under Section 3 of the Mental Health Act, 1987, the court *may* visit a patient before consigning her to an asylum. The visit thus becomes discretionary. There have been cases where women of sound mind have been consigned to mental asylums by their husbands and/or in-laws. Therefore, visits by the court should be not only made mandatory but also take place in the presence of parents and guardians or a non-governmental organisation (NGO). The right to visits by an NGO must also be made compulsory, enabling them to report on the condition of women in mental asylums.

Box 32.2

International Instruments that Obligate the Government to Ensure the Human Right to Health

- Everyone has the right to a standard of living adequate for ...health and well being of himself and his family including food, clothing, housing, medical care and the right to security in the event of ...sickness, disability...Motherhood and childhood are entitled to special care and assistance (*Universal Declaration of Human Rights, Article 25*).
- The states...recognise the right of everyone to...just and favourable conditions of work which ensure...safe and health working conditions...; ...right to ...an adequate standard of living...; the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken...to achieve the full realisation of this right shall include those necessary for ... the reduction of ... infant mortality and for the health and development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and

medical attention in the event of sickness (*International Covenant on Economic, Social and Cultural Rights, Articles 7.11 and 12*).

- States shall...ensure to (women) ... access to specific educational information to help to ensure the health and well being of families, including information and advice on family planning.... States shall...eliminate discrimination against women in ... health care...to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning...; ensure...appropriate services in connection with pregnancy... States shall ... ensure ... that (women in rural areas)... have access to adequate health care facilities, including information counselling and services in family planning... (*Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12 and 14*).
- States undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, colour or national or ethnic origin, to equality before law ... the right to public health, medical care, social security and social services.... (*Convention on the Elimination of All Forms of Racial Discrimination, Article 5*)
- States recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.... (*Convention on the Rights of the Child, Article 24*).

Source: *Advocacy Update*, No. 16, October-December 2001.

Laws Against All Forms of Discrimination, Exploitation and Atrocities

One of the most flagrant violations of women's fundamental and human rights – the right to life — is female infanticide and foeticide. The inverse sex ratio in the country is indicative of this blatant violation. The PNDT or the Prenatal Diagnostic Techniques (Prevention and Misuse) Act, 1994 (enforced in 1996), was enacted expressly 'to prohibit prenatal diagnostic techniques for

determination of sex of the foetus leading to female foeticide. Such abuse of techniques is discriminatory against the female sex and affects the dignity and status of women' (*Statement of Objects and Reasons of the Act*). However, due to poor implementation, there have hardly been any prosecutions in the seven years since the PNDT Act was enacted. Moreover, there are now more modern methods like the Pre-Implantation Genetic Diagnosis (PGD) or sex pre-selection technologies that can be used to select the sex of the foetus even before conception; these fall outside the purview of the PNDT Act (Mehta and Kothari 2001).

The Protection of Civil Rights Act, 1955, prohibits the preaching and practice of untouchability. However, violations of this law go unnoticed; access to drinking water sources by women belonging to the Scheduled Castes (SCs) and Scheduled Tribes (STs) is very often prevented.

Sexual exploitation of women and girls in the form of commercial sex work makes them vulnerable to physical and psychological health problems. Long hours of work, lack of rest, inadequate food, poor sanitation, sadism and violence make them vulnerable to reproductive and sexual health problems. Diseases like pulmonary tuberculosis, anaemia, Hepatitis B, sexually transmitted disease, pelvic inflammatory diseases, leucorrhoea, cervical cancer, infertility (as a result of STDs) and physical injuries are common among women in prostitution. The impact of prostitution on the psychological health of women and children manifests itself in stress, depression, hysteria, nightmares, insomnia, fear and revulsion to men and sex, suspicion of people, aggression, destructiveness and suicide. Child sex workers are especially vulnerable because they lack not only awareness to protect themselves from sexually transmitted diseases, but also the power to negotiate condom use (D'Cunha 1999).

The Constitution of India (Articles 23 and 24) provides for the right of a person not to be exploited; Article 23 prohibits the traffic of women for immoral or other purposes, slavery and bonded labour. Section 366 of the Indian Penal Code prohibits kidnapping and abduction of any woman or girl for immoral purposes. Section 366A

outlaws the procurement of a girl under the age of 18 years, while 366B prohibits the importation of a girl under 21 years from a foreign country for commercial purposes. The sale of a person under the age of 18 years and the purchase of a minor girl for the purpose of prostitution are also offences under the provisions of Sections 372 and 373 respectively.

The Immoral Traffic Prevention Act (PITA), 1986, aims to check sexual exploitation and trafficking. While prostitution per se is not an offence under this Act, it prohibits prostitution in its commercial form.¹ The punishment under this law is rigorous imprisonment for a term of seven years extendable to life if the offence has been committed against a child below 16 years. The PITA requires the setting up of protective homes for sex workers rescued from brothels and corrective institutions for those involved in commercial sex work or soliciting in public places for the purpose of prostitution. However, it is the women and girls who more often become the victims of legal action; traffickers generally manage to escape.

Sexual exploitation of young girls is sometimes rooted in certain religious traditions and customs. For instance, prostitution in the form of a religious practice, like the *devadasi* (handmaid of god) tradition, is highly prevalent in the states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu. Though Andhra Pradesh and Karnataka have Devdasi Acts that ban the practice, it continues regardless. The Devadasi Acts of these states mention only specific categories of *devadasis* like *jogins*, *basavis* and *matungis*, omitting other categories of *devadasis* who continue to practice religious prostitution.

Violence against women also adversely affects their physical and mental health. A bill against prevention of Domestic Violence has been drafted and tabled in Parliament and will be discussed in the February 2002 budget session. The laws that offer protection or redressal to women against domestic violence are mostly dowry-related. The Dowry Prohibition Act has been in existence since 1961. It outlaws the giving and receiving of dowry as an offence. However, the law has hardly ever been implemented. Most states still have no

Dowry Prohibition Officers. The maintenance of the list of gifts given to the bride by parents on occasion of her marriage is still not mandatory.

In view of the evidence of widespread violence against women and their unnatural death in matrimonial homes, Section 498A was introduced in the Indian Penal Code in 1983. It makes cruelty to women within the matrimonial home punishable with a fine and imprisonment of up to three years. The rates of prosecution and conviction have, however, been very low. The economic dependence of women and the limited options they have outside marriage constrain them from making official complaints. Women who take recourse to this law cannot expect to go back to their matrimonial homes; therefore, those without alternate shelter and financial support cannot consider this option.

Despite the legal provisions for sexual assault and rape, the rate of conviction in rape cases has been low. Because of the stigma attached to rape, there is considerable underreporting of cases. Adding to this is the insensitive handling of the cases by the investigating authority and the trauma of trial for the victims. Though the Supreme Court has held that, as a rule, the rape victim's version should not require corroboration and should be given credence, Section 155(4) of the Evidence Act allows delving into the character of the victim as part of evidence.

There are also laws to protect women in especially difficult circumstances, such as the Orphanages and Charitable Homes Control and Supervision Act, 1960. Though this Act mandates a minimum standard of education, service and training to the inmates, the pitiable condition of these homes reflects the poor implementation of this law.

Laws to Secure Women's Economic, Property and Inheritance Rights

There are several legal provisions to protect women from economic exploitation. Under the Equal Remuneration Act, 1976, the court of

the first class magistrate and the labour office have the power to inspect and file complaints, as do voluntary organisations. The non-payment of equal wages carries a fine of up to Rs. 10,000. However, women do not complain about receiving unequal pay because they fear losing their job. As a majority of women are in the unorganised sector, they do not benefit from legislations like the Employees State Insurance Act, 1948, the Minimum Wages Act, 1948, or the Workmen's Compensation Act, 1923. Despite the existence of the Trade Unions Act, 1926, a very low percentage of women workers are unionised.

With hardly 30 per cent participation in the labour force and the fact that the majority of women work in the unorganised sector, women do not really benefit from these employment-related-laws. Most women are economically dependent on their families. Personal laws that govern women's economic rights within the family, such as maintenance and inheritance, are unfortunately not conducive to women accessing equal rights vis-à-vis men; in fact, they serve to perpetuate and deepen inequalities.

The wife has a right to be maintained by her husband, during marriage, on separation and with alimony on divorce. Maintenance includes providing a residence, food, clothing, medicines and the basic comforts of life. The amount of maintenance depends on the income of the husband. The matrimonial home, the place the husband and wife cohabit after marriage, is often the only shelter a woman has, not only during the subsistence of the marriage or after divorce but also when she is widowed. The right of a woman to reside in her matrimonial home is recognised under common law. The Hindu Adoptions and Maintenance Act, 1956, recognises the right of a woman who has been treated with cruelty or deserted to claim a separate residence from her husband.

Regarding inheritance or succession to property, the Hindu Succession Act, 1956, has purged itself of gender inequality but only to an extent. Although Hindu daughters do inherit their parents' property equally with their brothers, they are not entitled to a share

in the joint family property or the Hindu Undivided Family. This is available to males only.² However, women can inherit shares from men, once the property is partitioned.

Economic dependence also affects women's health. It robs women of the power to make decisions regarding their lives and health. Especially vulnerable are widowed women who are often thrown out of their matrimonial homes and left destitute. A study found that most widows living in *ashrams* had no inheritance. In several instances they had been disinherited by their families and left to fend for themselves. In fact, they were forced to stay in *ashrams* because their property had been appropriated by others.

Widows are also subjected to maltreatment like restrictions on their mobility and autonomy, deprivation of resources in land, labour, irrigation, animals, housing, food and medical care. They face psychological abuse like enforced norms of behaviour, confinement, austerity in food intake and clothing, ostracism from religious and social life of the community and stigmatised as being inauspicious for causing husband's death. Physical abuse of widows is manifested in sexual violence, *sati* and witch hunting (Ranjan 2001). All this clearly impacts their health and well being.

Under the Married Women's Right to Property Act, 1939, a widow is only entitled to a life interest in the property of her deceased husband; she has no power of disposal over ancestral property. Under the Hindu Adoption and Maintenance Act, 1956, the father-in-law is obligated to provide for the maintenance of his widowed daughter-in-law, but only if she is unable to maintain herself or is unable to obtain maintenance from the estate of her husband, or her father or mother, or from her son or daughter if any, or his/her estate. Women thus find themselves at the mercy of in-laws after the death of their husbands. They become even more vulnerable if they fall ill and there are no earnings from joint family property or if the father-in-law is dead. These laws are ineffective, especially in rural and backward areas, where local customs wield greater influence.³

Conclusion

Access to health care is not a right and no government programme, however well funded and organised, can hope to provide universal access to minimum health. Laws pertaining to health alone do not ensure women's health.

In this context, the judiciary needs to be conscientised about women's concerns and issues so that judicial pronouncements on women-related cases are more empathetic. Also, since executive inaction often negates the objectives of the laws, the law enforcement machinery should be made more accountable.

Ensuring women's access to education and environmental safety should be seen as complementary to effective enforcement of laws. Social security systems need to be specially oriented towards the protection of women. Domestic violence and the physical and mental trauma that it engenders, deeply impact on women's health and need to be addressed not merely as a legal but also as a social issue.

Our laws are generally passive in nature, in the sense that they are set in motion only when invoked. Provisions for invoking the law in women-related cases need to be made more broad-based. The entire regime of women-related laws needs to be scrutinised. Individual laws need to be reviewed, rehashed and amended liberally to plug loopholes. Penalties also need to be made more stringent.

By and large, people are more aware of the constraints posed by laws rather than their advantages. A legal discourse on gender, especially in the area of women's health, would help in creating a lot more public awareness. If women's health is to be secured, the laws need to be implemented in a holistic manner, keeping in view their basic rationale and objectives.

Notes

- 1 The law is an amendment of the Suppression of Immoral Traffic in Women and Girls (Prevention) Act (SITA), 1956, which was tolerant of prostitution and did not outlaw prostitution if carried on independently, voluntarily and

privately by adult women. But it outlawed soliciting of customers and prostitution in public places. Unlike SITA, which assumes that prostitution is carried out only by women, PITA, 1986, aims to protect girls up to the age of 18 years and boys upto the age of 16 years from sexual exploitation and trafficking by providing higher penalties for offences, especially for those against children and minors.

- 2 This has changed in Maharashtra and Andhra Pradesh, where females can also be coparceners in joint family property. The Indian Succession Act, 1925, which is applicable to Christians, Parsis, and Jews, is quite complex and women get smaller shares than men, depending on their relationship with the deceased male. Muslim women are governed by uncodified laws and get lesser shares than men.
- 3 There are considerable regional variations in the inheritance laws for widows. A survey of rural northern India showed that widows' rights to their husbands' property are only upheld by the community if they maintain the land for their patriarchal lineage, i.e., their sons and future generations. If a widow leaves her husband's village with her children to remarry, she forfeits her rights to her husband's land and so do her children (Ranjan 2001).

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Part 8

Experiences with
Decentralisation and
Democratisation

*Chapter 33***Women and Panchayati Raj Institutions**

Susheela Kaushik

India is one of the few nations in world that has made special efforts to empower the weaker sections of its population. Through affirmative actions, India has enabled women, along with members of other disadvantaged sections to emerge as their own decision-makers in a new form of self-governance. Their experience and performance, against the backdrop of a traditional, feudal and patriarchal set-up, is bound to have important messages for the women's movement all over the world.

The 73rd Amendment to the Constitution of India, reconstituting and empowering Panchayati Raj, came into being in 1992. Within a year, the states had formulated their conformity legislations. Since then, all Indian states have completed their elections and brought the new Panchayats into existence. For the first time in India, nearly eight lakh women became members/chairpersons at the three levels of Panchayati Raj, thanks to the reservation provided in the 73rd Amendment. It included, as per the new Act, the election of scheduled caste/scheduled tribe (SC/ST) women to the extent of not less than

one-third of total SC/ST members/chairpersons.

This is indeed a unique experiment in the world of democracy, wherein women at grassroots level, irrespective of their educational, professional and socio-economic background, have been found suitable enough to occupy political positions and participate in legislating, decision-making and governing. For India, it is even more noteworthy, as the bulk of Indian women at the grassroots level are socially backward and not literate. Religious and sociological proclivities, customs, superstitions, unscientific norms and practices, caste and class hierarchies and rural-urban dichotomies are highly pronounced and hide-bound in the centuries old Indian culture. They have cumulatively contributed to preserving and strengthening patriarchal forces and practices. Not only civil society but even the state has often floundered on this rock and prevented women from participating equally in decision-making processes and governance. It is therefore worthwhile to take a look at the extent, level and nature of women's participation in the Panchayati Raj, wherever they have been in position for two to four years.

Over the last few years, several micro-studies based on research and training interactions have emerged on the experience of women. Many seminar papers and oral presentations, particularly by the Panchayat women themselves, have highlighted the role, functions, achievement and limitations of the women, both as members and as chairpersons.

The 73rd Amendment and Grassroots Democracy

The operationalising of the 73rd Amendment to the Constitution of India in April 1993 strengthened and constitutionalised the structure, powers and functions of local self-governments. With this empowering of the third tier of democracy, the democratic process in India has received much-needed boost and worldwide attention. Above all else, it has provided for devolution of powers and functions under Schedule XI of the Constitution and has required the states to gradually decentralise by transferring 29 areas to the local bodies.

There is also a mention of the Committee System and the state legislations are expected to prescribe the Committees.

Devolution of Power

Despite the Constitutional provision for the transfer of 29 areas, not many states have been able to devolve developmental functions to the Panchayats. In addition, under the 74th Amendment for Urban Local Government called the Municipalities Act, there is a provision for District Planning Committees (DPCs). These are combined Planning Committees for Panchayat and municipal areas. Every DPC is required to prepare a draft development plan for the district and forward it to the state government. The state legislature has the power to make laws for defining the composition and filling up of seats in such committees, define the functions and the procedure for electing the chairperson, etc. Not less than four or five of the total number of members of such committees are required to be elected from amongst the elected members of Panchayats and municipalities in the district by the members themselves, in proportion to the ratio between the population of the rural and the urban areas in the district.

However, the record of the states in willingly and promptly transferring the areas to Panchayats has been very dismal. The operation of Panchayati Raj Institutions (PRI) has shown that, even if constitutionally secured, it cannot be dissociated from broader political imperatives and manipulations. The commitment of the states to the spirit and objectives of local self-governance is therefore doubtful. In addition, not much visible advance been made by way of decentralisation of power and transfer of developmental schemes and resources to the PRIs.

The central government does not seem to be giving priority to the enforcement of the Constitutional Amendments. An occasional statement by the Prime Minister, or even the latest move to give developmental grants to select Panchayats in the country, has not helped to accelerate the implementation of the concept of local governance.

In the absence of speedy enforcement of the Act and effective

implementation of the provisions in letter and spirit, the participation of women and weaker sections threatens to be further reduced. No amount of education and training of women for political empowerment will have any meaning or use if the broader Panchayati Raj movement itself fails.

Some state governments have made what can only be termed as the beginning of an attempt in certain select areas. In the case of West Bengal and Madhya Pradesh, primary education up to Class V has been transferred to Panchayats. In Tamil Nadu, education has been brought under Panchayat Unions (block level). In West Bengal, primary health care has been entrusted to Panchayats. In Kerala, a Local Development Planning Board has been set up to devise such transfers.

In Madhya Pradesh and Orissa, the Women and Child Development Departments run the Development of Women and Children in Rural Areas (DWCRA) and Integrated Child Development Scheme (ICDS) programmes and both are supposed to be supervised and activated in close collaboration with PRIs. The state government has entrusted the newly elected Panchayats with the task of completing rural development projects, which include electrification of villages and propagation of non-conventional sources of energy. Besides, the Panchayats have been given wide-ranging powers in the field of social welfare, potable water supply, public health, family welfare, animal husbandry, dairy and poultry development, education, pisciculture, horticulture, sports, public distribution system, irrigation and welfare of SC/STs and the backward castes (BCs). However, in most of these instances, the decentralisation is in terms of monitoring and implementation rather than policy-making or programme formulation.

Committee System

Many states have introduced various types of standing committees to carry on the work of Panchayats. While there is now a plethora of committees, they appear to be more active at the district and block levels than at the Panchayat level. And nowhere is there any

mandatory provision for including women in these committees. It is also surprising that while the Social Justice Committees and Social Welfare Committees are common to all states, only Andhra Pradesh and Maharashtra seem to have specific committees for the welfare of women and children, and that too only at the Zilla Parishad level. The Health Committees, however, can be found in almost all states, especially at the Zilla Parishad level. In the Gram Panchayats and at the block level, there are 'Amenities Committees' in almost all states. Possibly, sanitation and public toilets figure as amenities. But there is no devolution as such of Public Health and Family Welfare to the Panchayats, even though it figures as one of the 29 areas. PHCs, ICDS and Anganwadi workers and Auxiliary Nurse Midwives (ANMs) figure as state government officials in almost all states.

Only in Orissa do the standing committees provide for a prominent role for women. The three standing committees meant for education, health and other distributive aspects insist that three out of five members be women. Such a provision is generally not found in other states; however, persons belonging to SCs, STs and BCs are preferred over others.

These features have much relevance for the effective functioning of women in the Panchayats as well as the decisions they can make for the development of the people in general and women in particular.

Population Policies: Two Children Norm

The Committee on Population Policies with Dr. M.S. Swaminathan as Chairperson recommended in 1994 that Panchayats should be utilised to make family planning popular among the masses. This seems to have struck a chord with the central government. The elected women Panchayat members thus came to be viewed as agents to carry out family planning.

This soon paved the way for viewing the elected women as models for family planning. The attempt by state governments to popularise the small family norm by dumping the responsibility for it on political aspirants to local government positions, appears to be short-sighted to say the least.

Haryana is one of the few states to attempt a notification on population control. On 23 April 1994, the Rajasthan government issued an ordinance stating that those who have more than two children would not be eligible to contest the Panchayat and Municipal elections. If a third child were born to a member after being elected, she/he would lose the seat. The announcement was, of course, stoutly opposed by the candidates as well as others on various grounds and was not implemented; it was held in abeyance for some time on the ground of giving at least one year for the people to prepare themselves as candidates. Andhra Pradesh and Orissa soon followed suit.

This policy, though propagated as a way of controlling population and thereby promoting women's health and public participation, is actually anti-women. It will debar a number of representatives of weaker sections from contesting elections to the Panchayats. The women aspirants will be affected most as they have very little control within their families to make such decisions as limiting the size of the family. Further, it will prevent those women and men who, having married young in keeping with the traditional practice in rural areas, may already have more than two children. It will also adversely affect the sex ratio, which in India is already unfavourable to women and stood at 929 women per 1000 males in 1991 and 933 per 1000 males in 2001. The adverse impact of this policy is already being felt, with quite a few instances of women being removed as chairpersons for having given birth to a third child or threatened to be confronted with a no-confidence motion.

Functioning of the Elected Women

The general opinion seems to be that the majority of rural women are illiterate, capable only of affixing their thumb impression on documents. By the same token, they are unable to negotiate themselves in a world of manipulative politics, and are further hindered by their ignorance of the intricate financial procedures and 'deals', and complicated development schemes and processes. In addition, constrained as they are by social norms and customs, they feel intimidated in the presence of elderly men and senior relatives.

Not being used to exercising their rights, it is not possible for them to successfully assert themselves or occupy positions in the PRIs. The cynics and critics are particularly sceptical about women performing effectively as chairpersons and vice-chairpersons of the three tiers of PRIs.

It is therefore necessary to examine the functioning of the new Panchayati Raj as to the extent to which women have come forward to utilise these new political opportunities; and even more significantly, to what extent will the new political operations at the local level allow them to do so.

Panchayats' Activities

What, in the opinion of the elected, are the activities of Panchayats? Or what are the ones in which they are involved? Most women believed the more traditional spheres like provision of drinking water, road construction, public works like maintenance of bridges, culverts and community halls, electricity supply, etc., to be the activities in which the Panchayats are involved. In this, they were not very different from the males.

However, women elected to Panchayats in more recent times, do have some ideas for women's development. They can spell out many special issues for women, with which they and the Panchayats should be concerning themselves. A fair number of elected women, particularly from Tamil Nadu, have emerged as being very conscious and aware. They have pointed to differences in the viewpoints of men and women and further confirmed that on almost all issues, women emerged as more progressive and empowered. It is possible that media exposure and mass literacy campaigns have had something to do with this modern outlook. Many of them have expressed that the women's point of view should be better reflected in the Panchayats' decisions. Economic self-sufficiency and income generation, women's education and schools for girls, emerged as major demands by women.

In several parts of India, Panchayat women have been unequivocal in their demand that alcohol should be banned. Some have come up

with issues like hostels for unwed mothers and homes for abandoned children as desirable areas for Panchayat action. In states like Himachal Pradesh and Haryana, there have been instances of Panchayat members and chairpersons leading demonstrations, breaking pots and resisting the police.

So how have the women performed in the Panchayats?

All Women Panchayats and Development Planning

The 73rd Amendment is a milestone in the history of legislation in that it has not only ensured women participation in leadership and decision-making roles, but also made sure that this provision is mandatory and applicable to the whole of India. But in some areas of the country, women occupied such positions and performed effectively even before the legislation was passed. In Andhra Pradesh, Karnataka and Maharashtra, women had contested elections, occupied reserved positions and contributed to the Panchayats' functioning years before the 73rd Amendment to the Constitution was made.

It is interesting to note that ever since the 1970s, Panchayat elections in India have been throwing up what are called 'all-women Panchayats', wherein all the members and chairpersons have been women. In Andhra Pradesh, during the 1970s, there was one all-women Panchayat at Mathupalli in Kurnool district, and another at Gandhinagaram in Warangal district in 1981. In Maharashtra, there was one all-women Panchayat in Nimbut in the 1960s, another in Vanjara in the 1970s, and eight more after the 1989 Gram Panchayat elections. All-women panels in nine villages contested these elections. In village Pidghara in Madhya Pradesh, situated 40 kms from Ratlam in Dhar district, all 13 members elected in February 1989 were women. In the present series of elections too, some of the states have thrown up all-women Panchayats. In West Bengal, village Kultikri in Midnapur district elected an all-women Panchayat. In Tripura, Mirza village of South Tripura district elected unopposed all its nine women candidates. A village with near-total tribal and

SC population, the nine members (five STs and four SCs) belonged to the CPI(M). In Karnataka, Mydolalu in Bhadrawati Taluq of Shimoga district has an all-women Panchayat. After the 1992 elections, Maharashtra has two all-women Panchayats at Brahmanagar (Pune district) and Bhende Khurd (Ahmednagar).

Quite a few studies have pointed out to the difference that women members, particularly in all-women Panchayats, have made to the nature of decisions in the Panchayat, and the process through which they were arrived at. They gave priority to issues like drinking water supply, installation of pumps, construction of toilets and village wells and roads, appointment of teachers, and closing of liquor shops. There were instances, as in the Vitner village of Jalgaon district (Maharashtra), where women got playgrounds built, land transferred to 127 women from their husbands' share and toilets constructed in the SC areas. Conscious of their increasing housework and the need to save energy and have some free time, the women in Pidghara (Madhya Pradesh) went for a 27-point action plan that undertook the building of educational and other community-based infrastructure.¹ A similar experience and action agenda has been reported by the seven-member Panchayat in Brahmanagar of Pune district.²

Another interesting example is from a village called Erikuppam in Thiruvallur district, where crude oil can be obtained at four feet. As a result, the water problem in the village had become extremely acute. The leader of the all-women Panchayat solved this by getting pipes laid from a neighbouring village in order to ensure water supply.

Even men found a marked difference in the working of Panchayats where the chairpersons are women.³ They said that women are more honest, sincere, active and work hard on village development activities. Corruption has also gone down, leading to more transparency in the functioning of Panchayats. It was evident that there are positive changes in society because of women's entry into Panchayats. The prevailing situation is reflected in the words of a male member from a block in Tamil Nadu: 'Though some women are uneducated, they have learnt about the functions, and even started

getting educated. Sometimes they do better than us.'

Constraints Women Face

To play their leadership and decision-making roles effectively, Panchayat women need the support of officials and the male members. The women feel very sore about the role of officials. The relationship between the elected members/chairpersons and the corresponding set of officials has become a very thorny issue. In many states, by bestowing on them implementing and monitoring powers, the Acts themselves have served to make the officials feel somewhat superior.

Many women members, particularly at the Gram Panchayat and Panchayat Samiti levels, have had no opportunity to directly interact with officials. The members of the Zilla Panchayat come across them more often. However, many among those who have interacted with them, or who have heard about their behaviour, found the officials uncooperative. Several felt that officials responded to male representatives more promptly. As a woman block president from Tamil Nadu said, 'Whenever we pass a resolution in our Panchayat on works to be carried out and take it to the Panchayat Union office, they refuse to accept it and impose a different decision on us.'

How do the women perceive their own functioning, role and contribution as local leaders? Most consider themselves to be representatives of the people in general as well as women's representatives. Many are not satisfied with their role and believe they are not able to work adequately for their community because they have not been delegated any power. They also cannot allot as much time to Panchayat work as they are expected to, mainly because of preoccupation with the family, and inadequate transport and health conditions. The women find it difficult to carry out their duties as Panchayat members because they lack adequate support structures. Tribal women feel this lack more keenly. A lot of women mentioned domestic assistance, childcare facilities, transport, political information, etc., as areas in which they needed support. However,

a majority of them were happy with their work and would like to be elected again. It was interesting to see that in Sidhi, one of the districts in Madhya Pradesh, sarpanches and *panches* (chairpersons and members) of different Panchayats are networking through newsletters to facilitate information sharing.

The women chairpersons would particularly like to get some help in

- a) maintenance of income and expense accounts
- b) finance generation
- c) leadership training
- d) training on planning for development
- e) support staff provision

All in all, however, many people consider the present system of Panchayats to be better than the old one. They believe that it is indeed working for the betterment of the people and that the presence and participation of women have made all the difference to its functioning. They also believe that the Panchayats are now more transparent and representative of all sections, particularly SC and ST. The outlook of most elected women is thus positive, confident and assertive. They are prepared to face obstacles and refuse to be cowed down by their limitations. Now that these elected women have entered politics, they would like to stay there.

If democratic decentralisation and devolution of power are to take place in any real sense, elected women in Panchayats will need to interact with village women, be guided by their demands and needs, and be supported and monitored by them. The formation and strengthening of Mahila Mandals and empowering the village people are therefore essential. Many organisations like SUTRA (HP) with projects like Sanjivini, Panchayat Mandalis and other NGOs training Panchayat women all over India are attempting to provide with the much-needed back-up support. Health care, schooling for girls, and education and awareness of their own rights are prominent on their agenda.

Notes

- 1 Singh, Manjeet. 1989. 'We want to outdo the males'. Reproduced in *Aalochana*, Women and Electoral Politics 1990-94, newspaper clipping.
- 2 Ibid. Vo.2; Subha Gandhari. 1994. 'The Rule of the Second Sex'. *Indian Express* (Bombay), December.
- 3 Opinions expressed in the National Commission of Women sponsored study of 'Panchayati Raj: A Stocktaking in Five States,' compiled and edited by Susheela Kaushik for the Centre for Development Studies and Action, New Delhi.

*Chapter 34***Decentralised Planning for Women's Health**
The Experience of Kerala

Aleyamma Vijayan

Kerala is one of the smallest states in India, comprising 1.2 per cent of the country's total land area and supporting 3 per cent of the population. Among other Indian states, it enjoys the unique position of having achieved all the major health parameters, such as birth rate, death rate, infant mortality rate (IMR) and expectancy of life at birth. This uniqueness lies in the fact that Kerala achieved this status in an environment of low per capita income and relative economic stagnation.

Some of the significant outcomes of this social development have been the demographic transition observed in Kerala in recent decades, an efficient public distribution system, numerous welfare and social security programmes and recently, a massive surge towards people's planning from the grassroots level upwards.

Without exception, all studies on the Kerala experience emphasise the crucial role that high female literacy has played in achieving these major gains. Other notable factors have been the favourable climatic and topographical conditions; availability of safe, potable drinking

water; hygienic and clean habits; and existence of sanitary facilities. Efforts made by the government to build up a sound infrastructure, capable of delivering health care to all socio-economic levels and to the remotest rural areas, have been equally important. The private sector, especially missionary hospitals, has also played a significant role in providing health care.

Emerging Concerns and Issues in the Health Sector

Although Kerala has made remarkable achievements on the health front, new challenges have emerged with changes in the demographic profile of the state, as well as due to other economic and socio-cultural factors. According to Dr. B. Eqbal, member of the State Planning Board (Handbook on Health-Planning Helper-3) some of the recent concerns facing the health sector are:

- The government hospitals are weakening. People are losing faith in them due to their inefficient functioning. Only 30 per cent of the people now use this facility.
- The private health care sector in Kerala has become a big business.
- Since government doctors are allowed to practice privately and since private facilities are used for most investigations like laboratory tests, a process of privatisation is taking place in the government hospitals.
- The growth of private hospitals has led to commercialisation and commodification of health care. The aggregate bed strength in private hospitals has increased by 40 per cent from 1986-96, whereas that of the public sector went up by only 10 per cent.
- The private sector also outpaced the state sector in the acquisition of medical technologies, such as Computerised Tomography (CT) scans, Magnetic Resonance Imagery (MRI) and endoscopy units. The resultant outcome is cost escalation and the marginalisation of the poor.

As a consequence of all of this, the health sector is witnessing the growth of a consumer culture with all its concomitant problems. Combined with the economic problems created by privatisation, and other problems like the re-emergence of communicable diseases and the emergence of new diseases; the increase in the so-called 'lifestyle' diseases like cancer, heart problems; over-the-counter purchase of medicines, self-medication and drug-induced problems, etc., this is posing new challenges in Kerala's health sector. The present situation is one of 'low mortality and high morbidity'. In the context of increased life expectancy, the problems of the elderly and chronically ill also pose new challenges. With the increase in educational standards, the unemployment rate in the state is also rising. The migration of a large number of Keralites in search of work has resulted in significant changes in the family structure. An increase in mobility has also meant an increase in tensions and frustrations. All these factors are creating serious problems in the mental health status of the Keralites. The rate of suicide in Kerala is three times that of the national average.

Women's Health Situation in Kerala

As indicated earlier, the maternal and child health situation in Kerala seems to be unique in the country. The system of Traditional Birth Attendants (TBAs) has almost disappeared and 95 per cent of deliveries take place in the hospitals. Yet, morbidity is very high. Since the general level of awareness on reproductive and sexual health and rights and women's issues and concerns is very low, these aspects get very little attention in the policy-making and planning process.

Although it is believed that the IMR in Kerala is as low as in the developed countries, recent studies by Dr. S. Irudaya Rajan and P. Mohanachandran of the Centre for Development Studies, Trivandrum, show that it is as high as 37 per thousand and not 14 per thousand as claimed by the government and other agencies. The study, while analysing the official statistics (on which the government

based its claims) in the 1996 Sample Registration System (SRS) provided by the Registrar General of India, found that out of 14 children who died within a year, 11 died within a week – a rate that is much higher than the national average. According to these studies, even if one accepts that the IMR provided by SRS was correct, stillbirth rates and prenatal mortality rates were extremely high. This indicates another of Kerala's paradoxes – low IMR, high stillbirth and within one-week mortality.

Another disturbing factor that has recently emerged in Kerala is the low birth weight of the newborn babies. Available studies indicate that the proportion of low birth weight babies was on the increase. The average birth weight had declined from 2.81 kg in 1987-88 to 2.65 kg in 1992-93. In 1981-82, only 11 per cent children weighed below 2.5 kg; the rate at present is 24 per cent. This is disturbing, as it shows the decline in the per capita average food consumption and the consequence of the policies in the agricultural sector. (In Kerala, a major shift occurred in the agriculture sector when the state forced farmers to shift to cash crops from food crop production. Kerala therefore became dependent on other states for its food requirements. Forty-two per cent of the state's population depends on the Public Distribution System (PDS). But in the targeted PDS, the central government has considered only 12 per cent as eligible for PDS.)

Yet another disturbing factor is the privatisation of health care and its impact on women's health. The state is moving to a situation of 100 per cent institutional deliveries and the entire process of pregnancy and delivery has become highly medicalised.

According to a study conducted by T.P. Kunhikannan and K.P. Aravindan (2000) shows that the number of caesarian sections has gone up considerably in Kerala:

'The percentage of caesarian sections has gone up from 11.9 per cent in 1987 to 21.4 per cent in 1996. This is only a rural sample. The urban figures are likely to be higher than this, which could make the caesarian rate in the state one of the highest in the world. A study conducted in

Thiruvananthapuram district found that caesarian *rates in some of the hospitals were as high as 60 per cent*. However, as per the WHO, no region in the world is justified in having a caesarian rate higher than 10 or 15 per cent. A caesarian section poses documented medical risks to the mothers' health, including infections, haemorrhage, transfusion, injury to other organs, anesthesia complications, psychological complications and a maternal mortality two to four times higher than that for the vaginal birth' (ibid).

Most doctors prescribe two or three scans during pregnancy. An average of seven visits are made to the doctor during pregnancy, which is higher than the average in Western countries.

Privatisation of health care also means that poor women's health is neglected. There are no facilities for delivery at the Primary Health Centers (PHCs). In a survey conducted recently, the women from slum and coastal communities spoke of the inefficiency, lack of infrastructure facilities, high rates of bribery, rude and unfriendly attitude of the staff, and lack of privacy in consulting rooms as problems faced by women in government hospitals. Although there is wide acceptance of family planning methods, the approach adopted is a women-centred approach. Of the couples that adopt permanent methods, the majority goes in for tubectomies.

Another serious problem affecting women in the state is the increasing sexual violence. Organised sex rackets are flourishing in the state where unemployment is also very high.

Awareness about sexual and reproductive health problems is low and women tend to keep their problems to themselves rather than consult a doctor. This is also true for educated women of high-income groups.

Decentralised Planning Process in Kerala

In accordance with the 73rd and 74th Constitutional Amendments, the Kerala Panchayat Act was passed in 1994, which paved the way

for real 'devolution of power' to local bodies and to the people through 'Gram Sabhas'. In order to actively involve the people in the Ninth Plan, a massive 'People's Plan Campaign' was started in 1996. About 40 per cent of the total plan fund is earmarked for spending through local bodies.

The State Planning Board is pioneering a unique experiment of decentralised planning in Kerala. Thus far, the various experiments in decentralised planning in the country had focused on the district or the block levels. Here, through appropriate Acts and Rules, the planning process is entrusted to the local Panchayats and every citizen is entitled to be a member of the planning process through participation in the Gram Sabha (assembly of voters in each ward of a local body).

Numerous hurdles need to be crossed before this process becomes a reality. 'Devolution of power' also means deployment of officials and their powers, funds, etc., and new rules need to be formulated for this. The people and the elected local body representatives have no previous experience in planning. A number of training programmes are therefore being conducted at various levels to fill this lacuna. Lack of sufficient data at the local level, lack of technical skills, etc., are other major problems. These too are being gradually tackled.

The decentralised planning process is generally categorised into needs-based and resource-based planning. In the needs-based process, acute problems faced by people are identified, resources to tackle these problems located, and development programmes planned accordingly. In the second approach, human and other resources and their potential are visualised, on the basis of which appropriate plans are made. The People's Plan comprises an integration of these two approaches (Thomas 1997). In order to ensure that the decentralised planning process is transparent, scientific and time-bound, a five-phase action programme is envisaged in the plan document.

Phase 1: Local problems and needs will be identified and prioritised in the Gram Sabha by the people themselves. All voters in a ward of

the Panchayat will constitute a Gram Sabha. The people in a Gram Sabha will be divided into 12 or more sub-groups, depending on the need. These groups will be in charge of areas like Agriculture and Irrigation; Animal Husbandry and Fisheries; Education; Industry; Drinking Water and Public Health; Transport and Energy; Housing and Social Welfare; Culture; Women; Scheduled Caste and Scheduled Tribe Welfare; the Cooperative Sector; and Resource Mobilisation.

Phase 2: Development seminar. This process will focus on finding solutions to the problems raised by the people with the help of relevant data, studies and locally available resources. Two people selected from each sub-group of the Gram Sabha and other experts, resource persons, etc., will participate in this seminar. An Action Committee will also be constituted to formulate projects based on the recommendations of the development seminar.

Phase 3: Project formulation by the Action Committee. At the end of this phase, a number of projects suitable for each area will be ready.

Phase 4: This phase will focus on the selection of projects, which can be executed by the Panchayats with available resources, and with state and central assistance. A plan document will thus be prepared.

Phase 5: In this phase, the village Panchayat projects will be coordinated at the block level and the block level projects at the district level. Thus projects for the block and district Panchayats will be prepared. Expert committees will also be formulated at this level to examine the projects, recommend changes and make them worthy of technical approval. The projects will then be recommended to the District Planning Committee (DPC).

Approach to Health

Health is considered as the most important area in the service sector. There is a general awareness that gains in the health sector cannot be sustained unless backed by improvements in basic living

conditions, such as drinking water, sanitation, housing and nutrition. Some of these can be addressed only through improving family income, particularly the income of women. In this context, experts are of the opinion that more emphasis should be placed on ecological and economic measures rather than on the further expansion of infrastructure facilities.

Two major aims of projects in the health sector, as envisaged by the Planning Board, would be to improve the quality of care and increase the outreach of services provided. The public health care system — from the PHC to the district hospitals — is now under the three-tier Panchayat system. (53 dispensaries, 938 PHCs, 105 community health centres, 120 government hospitals, 2 Mother and Child Health (MCH) centers and 13 Maternity Home units). The restructuring of the health sector with people's participation is beginning to take place.

The process of preparing a health plan at the local level started with discussions in the Gram Sabha. These were organised in subject clusters, with a separate group for health and family welfare, nutrition, sanitation and drinking water. In each group, a trained volunteer acted as a facilitator, providing the group with guidelines to focus the discussions. These contained points related to health infrastructure facilities, quality of services, sanitation, drinking water, nutrition, preventive measures, health education and other problems.

Each Gram Panchayat prepared a development report of their respective areas, with one chapter of the report devoted to health. Almost all the reports include a history of the area covered in terms of patterns of illness, health care systems, an analysis of major health indicators, their improvement over time, the factors that contributed to these achievements, and contemporary problems.

A review of the projects formulated during the last year reveals that:

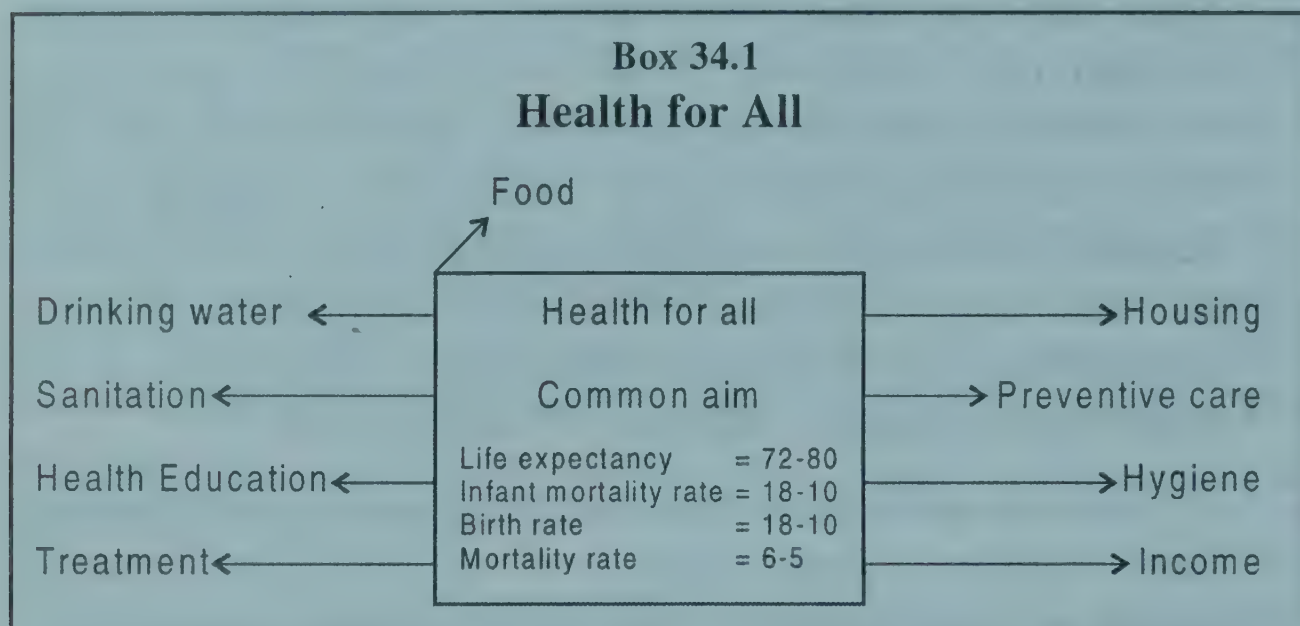
- Most of the projects in this initial phase are concerned with environmental hygiene and sanitation, health surveys and improvement of basic facilities in PHCs and Community Health Centres (CHCs). The Integrated Child Development Scheme

(ICDS) programme has been handed over to the local bodies and the ICDS supervisor is the main functionary of the Mother and Child Health (MCH) programme of the Panchayats and Municipalities. The local bodies can earmark funds to supplement the nutrition programme.

- Since sufficient funds are earmarked for the health sector from the plan funds, the resource crunch in the sector has been solved to a certain extent. In the Ninth Plan, approximately Rs. 600 crores have been allocated for sectors like drinking water, sanitation, education, environmental hygiene, etc. Of this, about Rs. 500 crores will be spent in the health sector alone. If, in the Eighth Plan, only 2.20 per cent was spent in this sector, in the Ninth Plan this amount will rise to 5.02 per cent.
- A collective spirit can be discerned in rural areas, with doctors, health-workers, elected members of the local bodies, and the public working together. They are no longer hampered by bureaucratic delays. Many doctors expressed that this was the first time that they have been involved in planning for the sector in which they work. However, there are also instances where the doctors feel upset about being answerable to the local authorities and the people.
- The people's campaign for decentralised planning has thrown up opportunities to experiment and execute new and innovative programmes. Health camps, blood donation camps, health card distribution, surveys to identify the health problems of the area, projects for the rehabilitation of mental patients, mentally retarded children, etc., are some of the projects taken up so far. A considerable amount of voluntary work is involved in these activities.
- A new approach is emerging with people taking responsibility and demanding accountability from the public health personnel. Local specific problems are getting due attention. A great deal of preventive health care is now possible. Other health systems like Ayurveda and Homeopathy are also being integrated. In some

places, there are attempts to study in detail the health problems of the general population of the area and then plan projects accordingly.

An integrated approach proposed by the State Planning Board for decentralised planning is given in Box 34.1.



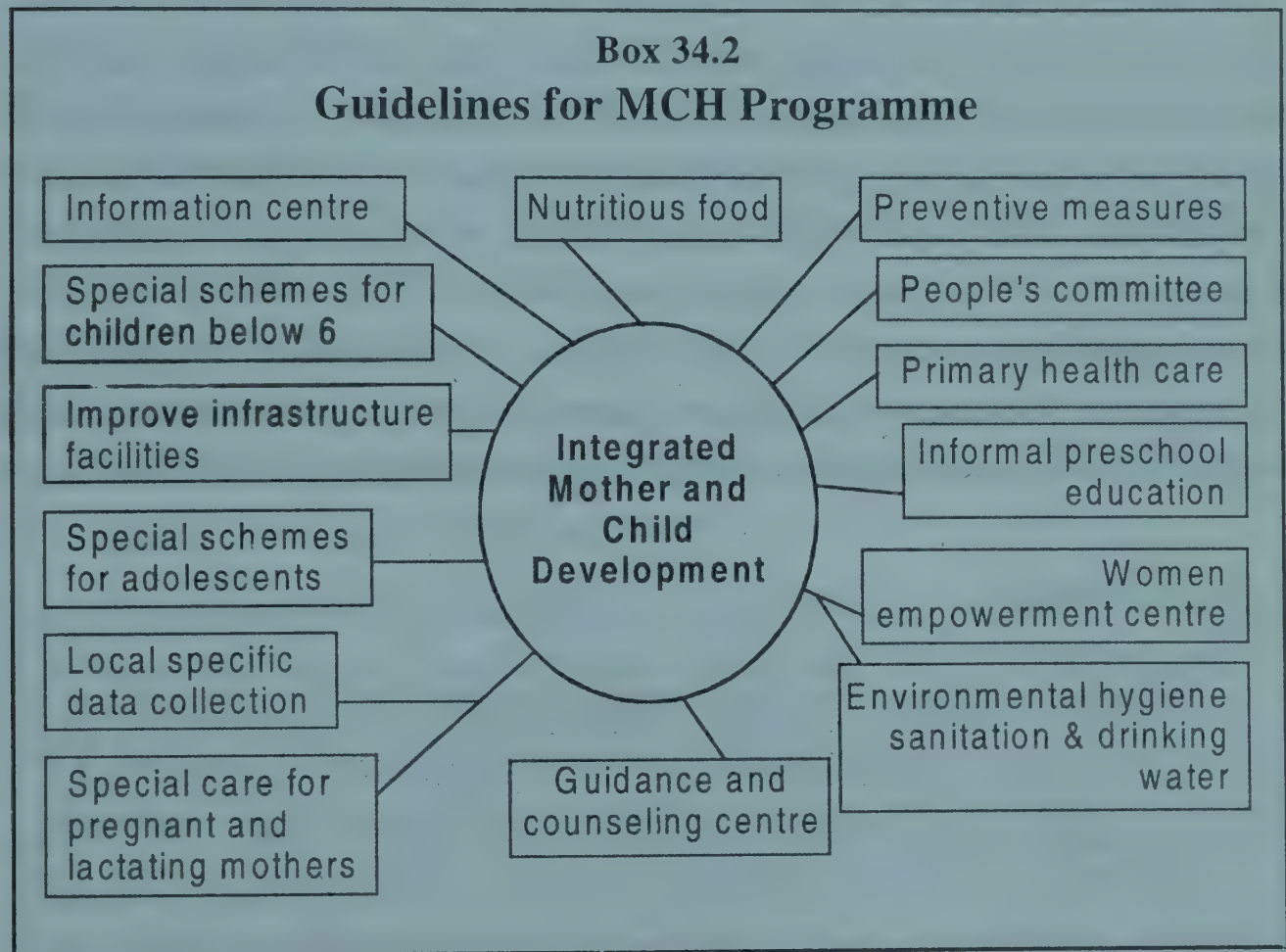
Decentralised Planning Process and Women's Health

An examination of the plan documents and the handbook prepared by the Planning Board on women's development, mother and child health and development, reflects the following:

There is a contradiction between high female literacy and the rather poor socio-economic status of women. The decentralised planning process should give special attention to study the status of women in their areas and evolve suitable projects to improve this. (Since an evaluation of the first year plan showed lack of sufficient fund allocation, the Planning Board has made it mandatory that 10 per cent of the funds be set apart exclusively for schemes for women; the District Planning Committee is authorised to monitor and ensure this before final sanction is given.) Women's health concerns are integrated with the ICDS programmes and the *anganwadis* are expected to act as centres of health education and women's joint actions. The ICDS supervisors and the *anganwadi* workers are

expected to help women form into neighbourhood groups.

Box 34.2 gives the guidelines that have been formulated for an integrated maternal and child development programme.



In all this, reproductive health, sexual health and rights do seem to be sufficiently reflected. The general lack of gender concerns and perspectives can be seen in the programmes proposed during the first year. Yet, in the second year, some Panchayats and blocks prepared some good projects. An example is the 'Integrated Social Health Scheme' formulated by the Ponnani Block Panchayat in North Kerala in collaboration with Indian Medical Association (IMA) and Mental Health Action Network (MHAN). In this Muslim-dominated block, a major thrust of the project is to discourage adolescent marriages, and give wider awareness on women's reproductive and sexual health. A handbook called 'Mother' has been prepared and widely distributed. As is said in the preamble of this booklet, 'It is hoped that awareness of one's body will help women for better family life and more control and power over their own lives.'

The municipality of the same area is issuing health cards for women and children. Cervix cancer detection camps, special supplement nutrition programmes, gender education programmes, etc., are some of the other projects planned.

Other innovative schemes introduced by the local bodies are the healthy village programme of Erattupetta, the people's primary health centre of Karavalloor and its health magazine, the mental health programme and gastro-intestinal disease detection and treatment programme in Mangalpuram, the manufacture of Ayurvedic medicine with people's participation at Malapattom, improving the facilities of hospitals through community participation at Nedumangad and Muvattupuzha, and the new cooperative hospital at Thrikkakara.

Limitations

The decentralised approach has been in place for five years now. It would therefore be interesting to review the impact it has had. The present challenge in Kerala's health sector is that of high morbidity, exacerbated by the simultaneous presence of diseases of poverty and lifestyle, stagnation in the growth of public health system, and escalation in health care expenditure. The decentralised people's plan campaign, with its allocation of 35-40 per cent funds, would therefore appear to be an efficacious way to face this challenge.

Yet, even in this process there are certain limitations, such as lack of reliable and correct data; inadequate resources like finance and availability of groundwater; absence of proper and scientific methods of solid waste management. It is also reported that active participation by local health personnel is lacking in the total health improvement of an area. Issues emerging from the globalisation process, like escalating prices of medicines and medical care, are also posing serious challenges.

Although the plan documents and handbooks make special mention of gender concerns, this does not seem to have percolated to the local level planning process. The Planning Board has set up a gender impact monitoring cell and also has insisted that the District Planning

Committees pass only projects that have earmarked 10 per cent of funds for women. But these measures alone are not enough to counter the deep and subtle patriarchal attitudes that prevail on the ground. In many Panchayats, women had to fight to get the 10 per cent funds earmarked for women-specific projects, as the men resented this and tried to get general projects like drinking water and sometimes even roads under them. Since people are not used to think with and for women, they are often, clueless about what would comprise appropriate and viable projects.

The situation of women's health projects is even worse. Even the handbook prepared by the Planning Board does not specifically talk about women's health concerns, except for anaemia and the quality of maternal and child health services.

What is reflected in the local plans and projects is what is discussed and proposed in the Gram Sabhas or by the Action Committees. There is a general sense of complacency that everything is well with the health status of women and their specific health issues remain invisible or unarticulated. Now, however, with the HIV/AIDS threat looming large in the state, more organisations have come forward to work with sexual health issues.

Suggestions for Policy and Programme Advocacy

General Suggestions

- Special efforts are needed to make the public health system vibrant and responsive to the health needs of people. Special incentives should be given to encourage doctors to work in rural areas (like tax subsidy on their earnings as suggested by the Indian Medical Association)
- All states should take steps to decentralise the planning process. Necessary laws need to be enacted by the respective state governments for this purpose and meaningful financial allocations made. Extensive campaigns should be conducted so that the new thinking becomes people's own.

- Comprehensive studies/data collection need to be undertaken to understand the specific women's health issues in each state, especially of women belonging to marginalised groups like the *dalits* or fishing communities, etc.
- Wider information dissemination of these concerns to planners and policy-makers should be undertaken to ensure that these are reflected in the plans and programmes.
- Model projects to address women's health concerns need to be formulated and proposed to the Gram Sabhas /action committees.
- A state-level consultative body of eminent but gender-sensitive doctors, women's health activists, etc., should be constituted to suggest priority areas and monitor projects.
- A 'People's Health Action Committee' should be formed at each PHC and CHC level. This should consist of doctors, paramedical staff, elected representatives, *anganwadi* workers, representatives of women's organisations, teachers, etc., and should be authorised to plan, suggest and monitor local-specific health action in consultation with the Gram Sabha. The committee should be funded and supported by local bodies.

Specific Suggestions

- All the PHCs should have facilities for normal deliveries. Other infrastructure facilities should be improved so that the centre becomes attractive and pleasing. Local Panchayats should earmark funds for the same.
- The services of a gynaecologist should be made available, at least in the CHCs, with privacy for consultations.
- Doctors' timings should either be rearranged to suit the needs of the people or they should be available round the clock, as in Tamil Nadu.
- Educational programmes using audio-visuals should be implemented to help women get a clear idea of their body and its functioning.

- Indigenous health practices should be documented and promoted in treating gynaecological disorders.
- Special efforts should be made to make men responsible in women's health and contraception. The responsibilities of health-workers should be reorganised so that male health-workers assume more responsibility, especially in reproductive health matters.
- Women's organisations should establish constant dialogue with policy-makers and planners so that women's health concerns get reflected in the planning process.
- Mass media should be used for wider dissemination of information and public debate on women's health concerns other than population control.
- Special efforts should be made to ensure and increase women's meaningful participation in the planning process. Audio-visuals, theatre, folk art forms, etc. could be used effectively for this purpose. Collaboration with NGOs and women's groups should also be pursued.
- Women are not a homogeneous category. The health needs of adolescents, older women, etc., (lifecycle approach) and women of different economic categories should be addressed separately.

Conclusion

Although the health situation in Kerala may be different from that in other states, the general approach to the problem is applicable to all Indian states.

The current paradigm of health sector development is increasing inequalities and alienating the poor and needy from the public health care system. The goal of universal primary health care service cannot be achieved if policies favour the privatisation of medical services. The decentralised planning process has many advantages: it offers an innovative approach to health care financing, enhances quality

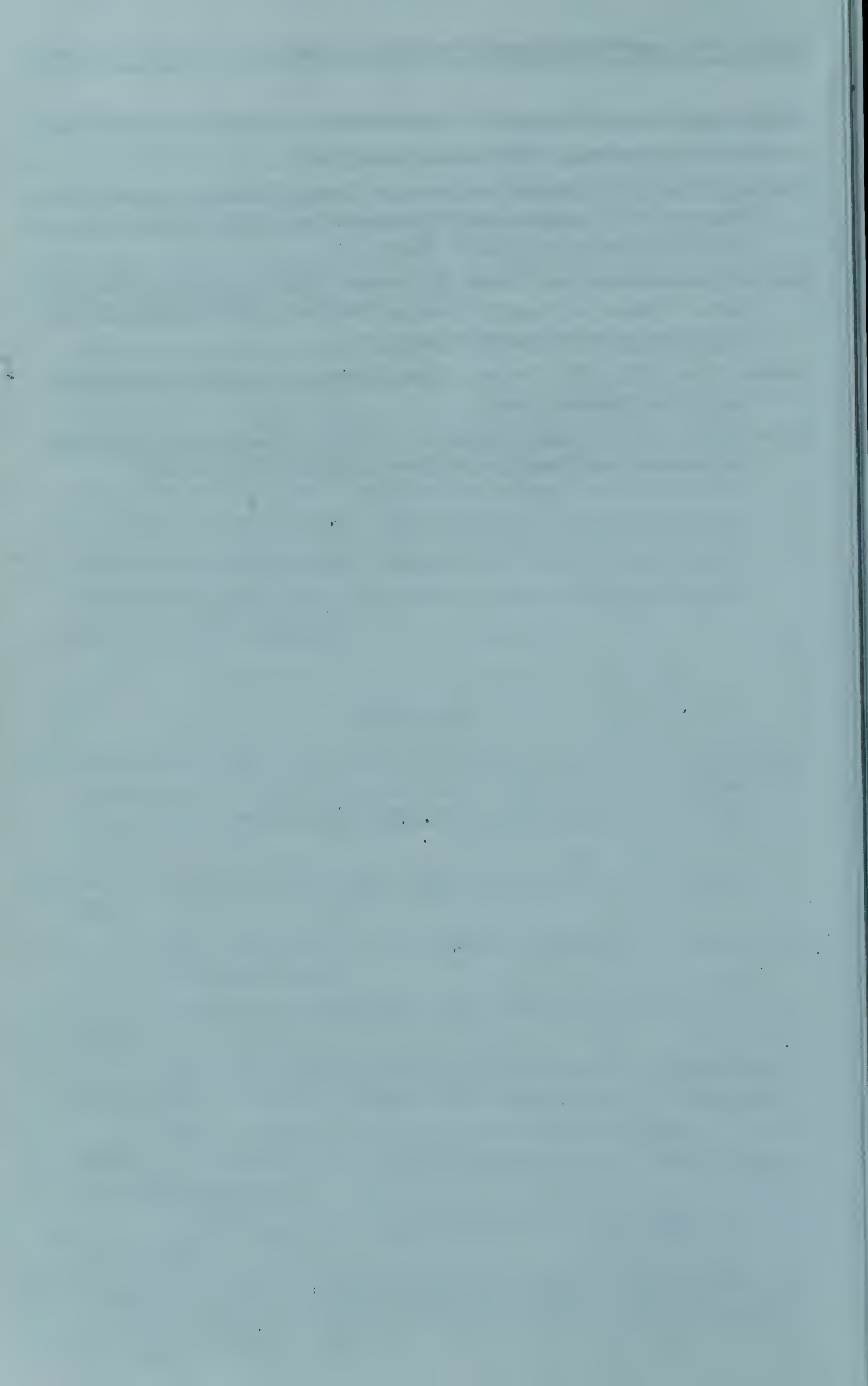
health care, emphasizes preventive over curative care, demands accountability from health personnel, and last but not least, enables participation by and empowerment of the people. Comrade E.M.S. Namboodripad, who was the Chairperson of the People's Plan Campaign, said in the first meeting of the High Level Guidance Council of the People's Plan campaign:

'True development can be possible only with a decentralised approach, where people take over the power to decide for themselves. If departmentalism has to end, old fortresses of bureaucracy erected between people and departments should be broken down. The humiliation suffered by ordinary people at the government offices and the system of begging favours from higher-ups, should end. Each citizen should feel that he is part of the government. The government should have the will to hand over power to people....'

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Part 9

Mainstreaming Gender

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*Chapter 35***Gender and Power Issues in Medical Education**

Thelma Narayan

Gender is currently recognised as a term that reflects the complex social relations between men and women (Kannabiran 1997, WHO-SEARO 1998). Accepting biologically determined differences as being more unchangeable, the focus is on socially constructed roles that have developed historically within and across cultures. This process of socialisation has led to the generally inferior positioning of women within families and in all other institutional groupings that exist in society. The underlying issue of power equations in the relationship, that manifests itself in terms of dominance, subordination, equality, inequality, role in decision making, control over resources, division of labour and access to services, is one that needs to be constantly reflected upon to ensure that the interests of more powerless and vulnerable groups are not made subservient to those that are dominant. Cross-cutting linkages with other power structures in society, such as class and caste or ethnicity, adds additional oppression to the position and condition of women in particular social groupings.

The internalisation of these social relations, roles and attitudes is deeply ingrained through socialisation processes during childhood and adulthood. They are reinforced by culture, traditions and religion, such that both women and men usually implicitly accept given roles. These social relationships, with their inherent hierarchies and positions of privilege, are characterised by conflict, often with the use of overt force and violence. A veneer of harmony may mask much subterranean 'silent suffering', which is part of the glorified and sanctified role assigned to women. However, social constructions are products of the human mind and though they may be reinforced by strong beliefs and ideologies, they can be deconstructed.

Position of Indian Women as Reflected through Health Indicators and Medical Practice

Available health indicators (or rather, indicators of levels of death and disease) provide evidence of the position of women in India. While globally the gender ratio (number of women per 1000 men) favours women because of certain biological strengths, the ratio in India from the turn of the century is adverse to women. More alarming is the fact that it has been consistently declining, despite 50 years of political freedom, decades of development efforts, and the spread of education. And it has continued to decline despite awareness created during the International Decade of Women and the efforts of women's groups throughout the country. All these liberative forces have not been able to dislodge sets of factors that seem to be very deeply embedded in our society. The continuing high rates of maternal mortality and high rates of anaemia among women point to deprivation of basic physical needs.

Sabu George and others (1998) have researched and documented the prevalence of female foeticide in Haryana and Tamil Nadu. It has also been reported from Maharashtra and Rajasthan, and probably occurs all over the country. Medical technology in the form of diagnostics, particularly ultrasound and amniocentesis, is used for sex determination, despite the national legislation passed in 1994

banning its practice. The finding of a girl foetus is usually followed by a Medical Terminal of Pregnancy (MTP), a practice legalised by the MTP Act and often conducted by qualified obstetricians. The selective abortion of girl foetuses is justified as an exercise of free choice by the parents and the mother. The medical ethical issues underlying these practices by medical professionals do not seem to find a place in the professional discourse of bodies like the Federation of Obstetricians and Gynaecologists, many of whose members are women. It is hypothesised that the practice of female foeticide is one of the reasons for the declining gender ratio. Private ultrasound and MTP services have been mushrooming even in small towns and large villages; at the same time, shortage of simple iron and folic acid tablets for anaemia (required particularly by pregnant women and costing just a few paise) were reported from all over the country in 1997 and 1998. This contradiction raises questions regarding the actual interests of both private and public sector health care services vis-à-vis women's health needs.

Based on years of research, Malini Karkal (1996) observes that asymmetric gender relations often cause discriminatory treatment of daughters within the parental family, and that this is further strengthened by marriage practices. It has been found that burns comprise one of the largest causes of death in young women aged 15-35 years, even more than pregnancy-related causes. One study in Mumbai found that 6 per cent of deaths due to burns occurred in the parental home and not in the in-laws' house as commonly believed. Karkal also hypothesises that patriarchy operates on age hierarchy, with ageing enhancing a woman's position in the family. Hence the support for patriarchy by older women.

High stress levels due to playing multiple roles cause women to have an increased vulnerability to mental illness, with feelings of helplessness, worthlessness, apathy, depression and sometimes suicidal behaviour (CHETNA 1996). Girls and women are socialised to tolerate discomfort and pain, often leading to delays in seeking care, support and treatment, with resultant progression of underlying disease processes.

Access to care is lower for women, as has been found in some studies looking at utilisation of inpatient and outpatient medical services. It is

suggested that part of the cultural definition of being a woman in India is her association with the 'inside', i.e., the confines of the home and the family (World Bank 1991). This restricts knowledge and access to services, including health care, but also to the 'outside' world where political and economic power is exercised (ibid.). The poor health status of women in India and their limited access to care is part of the overall iniquitous social position of women. While medical and health care can potentially liberate women through reduction of pain, suffering and death, medical professionals have sometimes misused medical technology to perpetuate an anti-women bias, as is particularly evident in the widespread practice of female foeticide and in the promotion of a family planning programme in pursuit of state demographic goals at the cost of women's health.

There is evidence that in India, women lack power in other spheres as well. For instance, in general, women do not own land; they have less access to markets; about 75 per cent are illiterate; and 90 per cent of rural and 70 per cent of urban women workers are unskilled (World Bank 1991). These factors, along with low purchasing power, lack of food security, poor access to safe water and sanitation, impact more adversely on the health of women and other vulnerable groups than do individual germs and bugs. It is necessary to assess how much and how seriously medical education addresses these underlying social/societal factors that impinge so greatly on health.

Gender and Medical Education

Medical education, both graduate and post-graduate, forms medical professionals, and along with research, informs medical practice. It also sets the guidelines and tone for education and training of allied health professionals. How does medical education confront and address gender issues? Is it sensitive and responsive to women's health concerns? Or is it yet another institutional arena in which gender issues get played out without being challenged?

Though medicine is commonly associated with objective scientific thought and methods in its practice, there is little rationale in the structure of

medical education. Historical factors relating to the growth, acceptance and dominance of certain disciplines, as well as the prestige attached to them at that time, resulted in greater or lesser allocation of time for their study. Thus anatomy receives a larger share of time, while psychology and psychiatry are still struggling for space. Sociology has not yet found a strong entry point and medical ethics is still on the fringes. The foundations of 'modern' medical education were laid during the period of 'scientific optimism'. There was little space for the social sciences, or for the experience of medical practitioners through their interaction with reality, for being able to raise questions concerning the social roots of disease and ill health or the relevance of medical prescriptions in the lives of people, particularly of women.

Thus, for instance, medical students spend the initial third of their undergraduate course with cadavers, frogs and biochemical experiments that bear relatively little relevance to their practice as healers. These are probably early steps in the process of dehumanisation, which later leads to a fragmented focus on organs and systems rather than on the whole human person who is suffering and in need of not just cure but also care. Medicine and medical education, though described as a social science, took a scientific trajectory and grew by reducing the problems being addressed to more and more specific detail of their biological components. The growth and faith in molecular biology and genetic intervention are evidence of this. Modern medicine has thus not related adequately to social and cultural reality, to intra- and interpersonal behavioural factors, and even more inadequately to conflictual social relations. A major lacuna in this regard is the lack of recognition given to women's health and gender issues.

Historical Developments

Historically, modern medicine and medical education came to India through the European colonial powers of the time (Portuguese and British). A process of gradual marginalisation of the Indian Systems of Medicine (ISMs) and folk health practices followed. The ISMs, though also urban-

based and to some extent elite, had a more holistic approach to the sick person as a total being and attempted to maximise and build up the healing powers within the person's body. An extensive pharmacopoeia and surgery had been developed by the ISMs over centuries of empirical observation, classification and codification. However, it appears that the approach to women's health focused largely on her role in childbearing and motherhood.

More importantly, however, the ISMs had traditional cultural links with local indigenous healing practices, including dietary and other preventive practices, which were widespread throughout the countryside. Women were largely the bearers of these local knowledge systems and practices. Western medicine, including gynaecology, 'gradually marginalised midwives (*dais* or traditional birth attendants), medicine women, women healers; they declared women's indigenous knowledge as non-knowledge'. (Bhasin 1997, p. 23). The marginalisation of ISMs occurred even in health planning and policy and this continued even after India gained political independence. Even today, ISMs receive about 5 per cent of the budgetary outlays for health at the national level. At the state level, some states accord ISMs slightly greater priority, though the major allocations still go to modern medicine. Western or allopathic medicine, by asserting and establishing a hegemonic dominance in India, has negated local systems of knowledge and medical practice and denied them a legitimacy that is theirs by right.

Policy Guidelines for Medical Education

A review of the Medical Council of India (MCI) Recommendations on Graduate Medical Education (MCI 1981) is revealing in terms of its gender sensitivity:

- a) While it mentions that 'the importance of social factors in relation to the problem of health and diseases should receive proper emphasis throughout the course', specific social factors such as gender are not mentioned. That social factors can be a cause of ill health and disease is also not considered.

- b) The importance of population control and family planning for health and development has been strongly emphasised, with a detailed curriculum for the teaching of Family Planning methods. A strong demographic agenda is evident, related to 'the needs of the country' as understood, determined and defined by the state. That women's health needs and interests may differ from state interests is not considered. Women have been made targets (Prakash 1983) and objects of methods that are themselves an iatrogenic cause of ill health, due to the side-effects of most of the available contraceptive methods.
- c) Obstetrics and Gynaecology in Phase III focuses largely on the obstetric, childbearing aspects. Thus 'not less than two-thirds of hours of clinical instruction shall be given to Obstetrics, including antenatal care, newborn care and maternal health'. Notice the lack of emphasis on the whole woman, and on the total dimensions of her health and well being at all ages.
- d) During internship, a posting in OBG is to be focused on 'antenatal care, family planning, contraceptive technology, operative techniques, sterilisation, newborn care, well baby clinics and paediatrics'. Again, a large lacuna persisted in the understanding and approach to women's health. Gender sensitivity was completely missing.

The gender bias in the content of the curriculum received comment from the Medico Friend Circle (MFC), an all-India 'thought-current' of persons interested in health issues affecting the majority population — the poor. The MFC was and is interested in socially relevant medical education and in women's health issues. In the 1970s and 1980s, there was no other social grouping in India that took up this issue (Narayan 1991). Dialectical discussions on the presence or absence of a 'sexist bias' in the teaching and practice of Obstetrics and Gynaecology also took place (MFC 1983).

The next revision of the MCI Recommendations, termed MCI Regulations (MCI 1997), made remarkable shifts in statements: from disease to health and from hospital to community, with an emphasis on

being relevant to service situations as existing in the country. It recognised the health rights of all citizens and called on doctors to fulfill their social obligations, to observe medical ethics; to appreciate socio-psychological, cultural, economic and environmental factors affecting health and to develop humane attitudes. This is indeed a positive change in the right direction. However, the MCI is again silent regarding the broader, total dimensions of women's health. Obstetrics and gynaecology continue to be biologically oriented and confined to the reproductive system. Five of eight teaching objectives relate to pregnancy, with only one 'to identify common gynaecological diseases and describe their principles of management'. Here, too, the medicalisation of problems occurs.

While pharmacology specifically mentioned the prescription of drugs during pregnancy and lactation, infancy and old age, psychiatry had no special mention concerning women's mental health. Additionally, the emphasis on 'analytical, logical, scientific thought and independent judgement' (MCI 1997), while useful, is too left-brained or masculine and needs to make space for integrative and collective learning, and intuitive creative abilities.

The new regulations seem to offer an opportune moment for greater interaction between Universities, those responsible for medical education and women's health, and gender-sensitive activists and scholars, to evolve gender-sensitive curricula and methods.

Content of Medical Education

There is need for a further review of the syllabus of each subject from a gender perspective and to make positive suggestions about the elements that need to be introduced, deleted or modified. While obstetrics and gynaecology, pharmacology and psychiatry could be the subjects to start with, the exercise should be done for all disciplines. For instance, all doctors in all departments need to be sensitised to the issue of domestic violence, which may underlie the presence of a woman with injuries at the surgical, orthopaedic out patients' department (OPD), or in casualty. The real cause of the injuries may

not be divulged unless the physician has the sensitivity and skill to get such a history. The support, care and professional intervention required in such a case is much more than just treating the wound surgically. Similarly, a young girl or woman may come in with burns – but underlying the burns could be the deep socio-psychological trauma that may prevent her from telling the truth or may even force her to make a false dying declaration.

In other instances, women who are raped need the professional advice of a forensic expert and of the local general practitioner. Paediatricians are faced with girl children who are brought in too late for treatment, or in other, worse situations, with children who are sexually abused. Dermatologists need to treat children and innocent women who have STDs. Research and other insightful studies have raised questions concerning common medical/surgical procedures performed on women, such as the practice of routine episiotomies for all primies, the increasing rate of caesarian sections and hysterectomies, and the use of the lithotomy position for normal deliveries. Thus, every aspect of medical practice, and therefore of medical education, comes face to face with gender issues. Medical professionals and, even more so, all allied health professionals are in a unique position where they can go beyond the immediate to address some of the deeper causes gender-related health consequences. But for this to happen, mainstream education would need to take on board the learnings from the women's movement and from research studies.

Methods of Medical Education

Methods of medical education need to move beyond didactic, hierarchical, exam and theory-oriented teaching to use interactive, participatory, problem-based learning methods, that are not only centred on student growth but also, equally importantly, relate to the social context and health needs of the people.

A number of innovative experiments have been tried out in India (Aryan et al. 1993). Some of these are not widely known or are lost to history.

However, there are streams within mainstream medical education that have always sought social relevance and have tried community-based or community-oriented approaches. These are the natural allies through whom gender-sensitive approaches could be introduced into medical education. Globally, there is the Network of Community Oriented Educational Institutions for Health Sciences, whose membership includes a few Indian institutions and individuals. It was initiated with the help of the World Health Organisation (WHO) and continues to have its active support. At their annual meeting in 1994, a suggestion was made by Pakistan and India for having a women's health cell. This could be further pursued. Their journal is appropriately titled *Education for Health*.

Some Indian Universities have taken the lead in introducing progressive changes. Mumbai University is introducing women's studies as an integral component of several of their courses. The Rajiv Gandhi University of Health Sciences – Karnataka, in Bangalore, is restructuring the curriculum based on the 1997 MCI Guidelines. It is one of the first Universities to introduce the teaching of Medical Ethics throughout the course. Thus, there are windows of opportunity that can be used to promote an understanding of gender and power issues in medical education that will also translate into action in the educational programmes offered.

Values in Medical Education

In the current scenario of globalisation, liberalisation and commercialisation, which includes the commodification of women and of medical care, it is important to emphasise and reiterate in medical education certain basic values in health. These include equity, social justice, ethics, gender sensitivity, sustainability and self-reliance. There could be many others, such as respect for plural people's health traditions, and cultural sensitivity.

Women in Medical Education and Medical Care

A detailed review of medical education found increasing members

and proportions of women medical students gaining admission and graduating from medical colleges across India (SOCHARA 1995). From 21.5 per cent in 1971-72, admissions of women students had risen to 39.8 per cent in 1989-90. However, gender differences in admission to the prized post-graduate specialties of surgery and medicine remain. Gender discrimination is also reported to occur in promotions, with women considered to be unavailable to handle all the responsibilities due to the double burden of also managing their families and homes. As in all other occupations, this raises the issue of joint responsibility for child care and home management. Women physicians in Delhi have been reported to have a better status than in the past, also occupying leadership, and decision making positions as heads of departments and institutions. However, they are still viewed as occupying specialisations that are less academic and inferior (Nigar 1993). The number of women in cardiology, neurology, medicine and surgery, disciplines that are seen as requiring greater abilities, is still marginal (*ibid*). Studies abroad reveal that women are more concentrated in primary care, including family medicine, paediatrics and psychiatry (Notzer and Brown, 1995). They report that repeated studies have found women doctors to have a more humanistic and personalised approach to patient care (*ibid*).

A brief review of the literature reveals that many women medical students experience sexual harassment during their undergraduate and postgraduate period and during registrarship, including psychological abuse and discrimination because of sex. While this has been reported from Canada (Myers 1996, Philips 1996) and elsewhere, it is not a dimension that has been researched in India. It is difficult, therefore to estimate its extent. However, its occurrence itself reflects the position of women in society.

As can be seen, there is tremendous need for further work on gender and power issues in medical education. Besides research and analyses, the coming together of different streams, with networking and sharing of experiences between groups, is also required. Most importantly, there is need for engagement with bodies concerned with medical education, such as the Medical Council of India, Health and other Universities, and the Indian Medical Association.

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Chapter 36

**Gender Sensitisation of
Health Care Providers**

The Women-Centred Health Project, Mumbai

Renu Khanna, Swati Pongurlekar, Usha Ubale

The Brihanmumbai Municipal Corporation (BMC) provides health services to approximately three million women in Mumbai, especially to the poorest women who cannot afford private health services. Historically, the services provided by BMC for women have been largely developed from a population control perspective and in many respects fail to take into account women's reproductive needs. The training of Auxiliary Nurse Midwives (ANMs) is aimed at mobilising women for birth control and sterilisation and does not prepare them to share information on the basis of women's needs.

Based on the findings of a study on the clinical and social aspects of Pelvic Inflammatory Disease (Brabin et al. 1998), the BMC took the initiative to develop more women-centred services. The Women-Centred Health Project (WCHP) was thus born as a collaboration of the Public Health Department of the BMC, SAHAJ (Society for Health Alternatives) — a non-government organisation, the Liverpool School of Tropical Medicine and the Royal Tropical Institute at Amsterdam. The goal of the WCHP is to improve the quality of care within BMC

from the perspective of women, especially the quality of sexual and reproductive health. The Project covers two wards of Mumbai and a population of approximately 10 lakh. The specific objectives of the Project are to:

- implement reproductive health care at the health post and dispensary levels by increasing the range of services on prioritised reproductive health problems, and by involving men;
- establish and implement quality assurance mechanisms, including better provider-client communication, woman-friendly treatment procedures, and improved referral links;
- implement woman-friendly Information, Education and Communication (IEC);
- build capacity of the staff in the two Project wards and the other wards in BMC;
- disseminate and mainstream the learnings of the WCHP.

Gender and BMC

In 1995, when the planning for WCHP was initiated, BMC's Public Health Department reflected the situation that existed in most public sector institutions in India with respect to gender awareness. Most public health institutions in the country exist in the context of patriarchal structures, inequality in power relations, inadequate access to resources for women and the poor, lower value attached to women's roles and their work. Inequalities between men and women can be derived from census and hospital bed occupancy figures, where bed strength is significantly greater for men than for women. For instance, the bed strength for tuberculosis patients was 792 for male patients and 208 for female patients¹ (TB Hospital, Sewree.) (WCHP 1999). That gender-sensitive policies and programmes are required was not recognised within the BMC where, although the majority of Public Health Department employees were women, most senior positions (except the Executive Health Officer) were occupied by men. Gender awareness of the senior staff was limited to the understanding that women suffer from special conditions, such as

infertility and sexually transmitted diseases (STDs), for which insufficient services are available. The pattern of health services provided reflected acceptance of traditional gender roles: women were considered important only in the reproductive context. The Health Department's services regarded women as 'mothers' and 'caregivers' but not as decision-makers: the department's policies demanded husbands' signatures for procedures like medical termination of pregnancy and tubal ligations. Providers' perceptions of women as peacekeepers in the family influenced their actions and decisions in treatment provision. For instance, in discussions, health care providers stated that they were reluctant to inform women about STDs because they feared that this might result in domestic conflict.

Primary health care facilities like the health posts, post-partum centres and maternity homes provided services mainly for family planning, and maternal and child health (MCH) care, and are perceived by the community as meant for women only. Men are not encouraged to visit clinics, such as mother and child health clinics, maternity homes and gynaecological clinics, that are considered to be women's spaces. This prevents them from playing a more supportive role.

Efforts at Gender Sensitisation through WCHP

The efforts at gender sensitisation undertaken by WCHP included (a) training inputs; (b) gender sensitisation of senior officers; and (c) other interventions like mainstreaming gender in the quality assurance process, the IEC Cell of BMC, the Management Information System (MIS) Cell, the Men's Involvement Project, and so on.

Training Inputs

WCHP has been providing ongoing training to approximately 400 health care providers of the two project wards. Gender and health modules have been part of each training workshop conducted by WCHP. To train the 400 health care providers, a group of 20 Key Trainers have been prepared through four Training of Trainers workshops, each spanning three to four days. Around 80 Auxiliary Nurse Midwives (ANMs), Male

Health-workers (MPWs) and Public Health Nurses (PHNs) have been trained in three workshops of four days each.

About 30 medical officers have gone through classroom training as well as practical training supervised by teaching hospital faculty. Every month, the medical officers organise regular Continuing Medical Education sessions to discuss clinical cases and the social dimensions of clinical conditions. For the first time, around 250 community health volunteers, who are local women from amongst the 'beneficiary' women, also received formal training from the WCHP Key Trainers.

The training included topics like gender and sex, differential social norms/rules/customs for men and women, gender roles, rights and responsibilities, access to and control over resources, power and decision-making, construction of male and female sexuality and their relationship to health, and how different diseases affect men and women differently. In addition, the participants were encouraged to apply these concepts and do a gender analysis of (a) BMC's health department as an organisation; and (b) the services provided by the BMC.

A wide and innovative range of methodologies like creation of a story, analysis of case studies, small group discussions, sharing personal reflections and so forth was used for the gender training. The outcome of certain training sessions reflected rich analysis by the participants and helped build a body of knowledge related to gender and health in BMC.

Gender Analysis: Providers' Perceptions

This analysis was done by a cross-section of health care providers who are part of the Key Trainers' group of WCHP. The reports of this group work brought out how the health care system, i.e., the Public Health Department of BMC, perpetuates gender differences.

The health care system is oriented only towards women and limited to their reproductive role.

- Family planning services target only women.
- IEC activities of Community Health Volunteers (CHVs) target only *mahila mandals*.

- MCH services do not involve men.
- Personnel policies are discriminatory; men have more avenues for promotion; no paternity leave.
- There are more female than male staff, but none in key decision-making posts.

Roles and division of labour within the health department are highly gendered.

- More women do menial jobs; all attendants and *ayabais* are female.
- All CHVs are female; there are no male CHVs to work with men.
- Women workers have more workload and tasks (antenatal care [ANC], post-natal care [PNC], family planning motivation) than male workers

When asked how social norms affect the health of men and women and the services provided in the BMC, the Key Trainers related gender identities, roles and images with health-seeking behaviour.

Social norms affect the health of men and women.

- The belief that 'women should be shy and not talk about health' prevents them from seeking treatment.
- Many BMC medical officers are male; many women do not want to be examined by male doctors.
- Due to men's productive roles, their health is given priority and women neglect their own health.
- Women are blamed for infertility and birth of female babies.

Rights and responsibilities.

- Women have no voice in relation to their own health. They need men's permission to get tubal ligation, while vasectomy does not require the wife's signature.

- Childcare is considered solely a woman's responsibility. In the paediatrics ward, only women are allowed to stay during the night, while in outreach services, fieldworkers teach only women about childcare. Only women are motivated to bring children for immunisation. There is no role for fathers in child rearing.

Resources: access and control.

- Women are economically dependent on men and cannot decide on their own to seeking treatment.
- Due to restricted mobility, they lack access to information.

Decision-making and control.

- The husband and in-laws decide the number of children a woman should have.

Participants identified differences in power and decision-making of women and men in relation to health. The results show how health care providers support and reinforce men's and in-laws' publicly accepted role as decision-makers, husband's greater access to and control over resources and how this affects choices of birth control, access to information and treatment.

Diseases affect men and women differently.

The Key Trainers and CHVs analysed the effects of diseases like TB and infertility on women and men. They did a fairly good job of the analysis. While bringing out the differences in the biological and social effects of these diseases on men and women, they emphasised that as opposed to the physical and biological effects, the social repercussions of the diseases on women were far graver; and between men and women, it was women who bore the brunt of societal attacks.

Life Cycle Approach to Women's Health: Clinicians' Perceptions

In their training, the clinicians were asked to define the different stages in a woman's life and to identify her health needs and problems at each stage. The group reports reflected that while clinicians were able to relate

gender causes with the health problems of the girl child and adolescent girls, they were not able to make the same linkages with the health problems of women in the childbearing age group. One reason for this may be the mass campaigns and propaganda for the rights of the girl child and adolescent girls that have registered in the consciousness of the clinicians. The reason for their not being able to see women in the reproductive age group as gendered beings may be due to the effects of their basic medical education that is highly biomedical in content and lacks a social perspective.

Gender Sensitisation of Senior Officers

As a first step to sensitise policy-makers and senior administrators of the Public Health Department, needs assessment meetings and workshops were organised. In one such meeting with around 15 senior-most officers of the Public Health Department, it emerged that there was low understanding of the meaning of gender; they did not perceive any gender discrimination or difference (Box 36.1).

A two-day gender sensitisation workshop was therefore organised for 18 senior officers. Apart from providing clarity on concepts like gender and sex, practical and strategic gender needs, construction of power, and gender-blind, gender-specific and gender-just policies, the workshop encouraged participants to examine how institutions like the family,

Box 36.1

Baseline Perceptions of Gender

'We do not have any such problem as in Uttar Pradesh; both male and female workers work equally and are treated equally in Mumbai. In fact if there is any problem like heavy rains in Mumbai or some other crisis, we send female staff members home early and men are asked to wait back.'

A Senior Officer, male

'In my home I do all the work that my wife does, so we are not treating women differently.'

'All people use our services equally and there is no such problem except a **small** thing that only women come forward for family planning operations and men do not come forward *at all*.'

community, state and market perpetuate gender inequalities. In small group discussions, they analysed the causes for the lack of gender focus in vertical programmes like TB, Malaria, AIDS Control, Leprosy, and Family Welfare; lack of gender-specific MIS for planning, monitoring and evaluation of programmes and inadequate gender sensitivity in the Public Health Department as an organisation. On the basis of their analysis, they drew up an immediate action plan that was later submitted to the Executive Health Officer. The plan has been accepted and is being implemented in phases. For example, gender issues have been included in the training sessions of WCHP, BMC's in-service training and under the RCH project. Partner treatment, awareness of decision-makers in the family, is a part of the RCH training; under the TB programme, data collection carried out by the disease surveillance department is disaggregated by sex; emphasis on male methods has been included as part of the training of MPWs under the RCH programme; staffing – appointment of female medical officers and MPWs – is to be reorganised under the RCH programme; male fertility clinics are also to be implemented under RCH; gender-sensitive indicators for monitoring are to be developed by the MIS Cell.

Mainstreaming Gender: Other Interventions

Quality Assurance (QA) Process

An important objective of WCHP is to improve the quality of services being provided by BMC and to institutionalise QA mechanisms. The QA intervention is an action-research process designed by WCHP through a series of five workshops conducted over a period of four years. Quality of care has three dimensions:

- clients' perspective
- professionals' perspective, and
- management's perspective

The clients' perspective on quality of care was emphasised from the very first workshop. One outcome of the first workshop was a patient

satisfaction study that explored women's and men's perceptions of the quality of services provided by BMC (mainly women, because more women than men avail of primary-level health services). The second workshop identified three pilot areas for developing tools for monitoring aspects of quality. These were: drugs availability for patients, referral to secondary health care facilities, and provider-patient communication. The drug availability study made special effort to determine whether medicines for women's gynaecological problems (other than limited to her reproductive role, like vaginal pessaries for Reproductive Tract Infections [RTIs], and so on) are available at health posts and dispensaries. Similarly, the provider-patient communication study was based on the recognition that ways in which poor and marginalised women communicate with health care providers are a result of various factors like their culture, language and perceptions of power.

QA interventions also focus on provision of privacy — especially for physical examination of women, woman-friendly history-taking, examination and treatment procedures. Protocols were developed on these aspects as a part of the Clinicians' Training (see Chapter 10). However, men's reproductive health needs have so far not been addressed.

Information, Education and Communication (IEC)

The first objective of the Project related to IEC is to prepare need-based, gender-sensitive IEC material to address men and women's concerns, doubts and information needs on reproductive health issues. The Project conducted several activities towards this objective. Group meetings held in the community showed that the men's and women's perceptions and information needs are different from those perceived by health care providers. A review of existing IEC material (produced by the state government and some by the IEC department) revealed that it projected men and women in gender stereotypical roles. Men from *bastis* expressed that they wanted males from the Health Department to facilitate group meetings in the community and answer their questions related to sexual health.

The process of developing material on RTIs by incorporating women's

perspective and information needs was initiated through a workshop involving NGO members and the health-workers. The material, which included a section on role of men in RTIs, was field tested among groups of men and women before being finalised (see Chapter 13 for a description of the process).

Management Information Systems (MIS)

The main goal of the Project is to improve the quality of services provided by the health post and the dispensaries. In this context, though health posts do generate some gender-disaggregated data, this is not being analysed by BMC. Within the RCH Programme, there is insufficient attention being paid to gender-sensitive indicators for reproductive health. The Project thus felt the need to study the existing MIS system and pilot-test some indicators for gender-sensitive reproductive health. The WCHP has therefore proposed a workshop with the MIS officers and RCH Managers in the Public Health Department to initiate the process of field-testing.

Men's Involvement Interventions

Contrary to what its name may suggest, the WCHP aims to involve rather than exclude them from the Project. Men's involvement is required as a support for women in negotiating sexual relationships, and to encourage men to address their partners' vulnerability to reproductive and sexual health problems. As a beginning, the Project is studying women's perceptions of their partners' involvement in their reproductive health issues. Simultaneously, men's perceptions of women's health and their actual involvement in their partners' reproductive health milestones (for example, childbirth, MTP, gynaecological problems, etc.) are also being explored. This study will help clarify what men's role in women's reproductive and sexual health can be from both women's and men's perspectives and also help in identifying strategic interventions and opportunities for education and information.

In addition to the study on men's involvement, the Project team members, some male health-workers and social workers are being taken through a training and sensitisation process on the construction of masculinity and male sexuality to broaden their perspective on issues of power and

control in sexual relationships and help them to do gender-sensitive counselling.

Outcomes of Gender Sensitisation

Training Evaluation

After each training workshop, its impact on the trainees' knowledge and attitude was evaluated. A pre- and post-training questionnaire was administered to all workshop participants. The questionnaire not only covered the social aspects of the reproductive health conditions discussed in the training, but also included case studies to assess the trainees' ability for critically analysing the situation and making non-judgemental decisions. Analysis of the results showed significant increase in the knowledge of ANMs and MPWs. In the post-training evaluation, 43 of the 47 respondents could define gender and satisfactorily discuss the importance of gender issues in the implementation of health programmes. The Key Trainers' pre- and post-training evaluation showed that issues related to women's health were better understood after the training by 50 per cent of the participants. Most participants showed an increased understanding of various socio-economic factors affecting women's health, the special needs of women and the gender issues affecting their health.

A recent comparative study of Pelvic Inflammatory Disease (PID) ANMs, ANMs from the Project wards, and those from control wards² showed that the understanding of social and gender issues in women's health was of a similar level among ANMs from the Project and control wards, but that of PID ANMs was significantly better.

Evaluation of Senior Officers

The senior officers found the gender sensitisation workshops informative and thought provoking. Some of the major learnings, which they planned to integrate into their work, were:

- Gender and not just poverty affects women's health adversely right through their life cycle; women's health is reduced to their

reproductive health needs (10 respondents).

- Some diseases in men and women have different rates of prevalence (2 respondents).
- Diseases are both characterised and impact differently on men and women (4 respondents).
- Some health problems exclusively affect one or the other sex (2 respondents).

Mid-term evaluation

During the mid-term evaluation conducted by the WCHP in July 1999, 28 out of 30 ANMs, MPWs and PHNs who evaluated the training stated that they liked it, particularly the sessions on gender, infertility and counselling. These topics had been introduced to them for the first time. They reported a change in their perspective on women's problems, with 20 out of 30 claiming that they had begun applying the knowledge gained from the training in counselling for cases of infertility and TB. The Medical Health Officers of the two project wards, who administrate and supervise all health posts, dispensaries and maternity homes within the wards, also expressed appreciation of WCHP activities, describing the training as 'really good' or 'very good'. The senior staff were also appreciative. The impression gained during a recent workshop with senior officers on disseminating what they had learned from the WCHP training, and mainstreaming the learning in the forthcoming RCH Programme, was that the system has already begun to internalise the concepts of quality of care, gender and 'listening to women'. These terms are being freely used by a growing group of 'younger' officers within the Public Health Department.

Problems and Challenges

Several problems and challenges still remain. Gender sensitisation at the top level obviously cannot be achieved in a two-day workshop. Senior officers have time constraints and busy schedules that hinder their participation in training workshops. Though there is a significant shift in

Box 36.2**Changes in Perception and Practice at Mid term****Medical Officers of Health**

'(Training activities) really good. It facilitates the exchange of views among the trainees. Pooling together the suggestions of the participants helps them to change their opinions.'

'(Training activities) very good. Made me look into things happening in our own family. This made us think of the gender issues.'

Paramedical Staff

'I have realised that men's involvement in family planning is negligible and we need to make more efforts to involve men.'

'A couple called me to the house and asked me why the wife has not conceived even after three years of marriage. I could give them proper information and support.'

the mindset of some younger officers, many people feel threatened by the concept of gender and there is a tendency among participants, particularly among MPWs, to trivialise gender issues. Workshops on Construction of Masculinity and Male Sexuality, which were planned early in the Project for MPWs, could not be conducted due to opposition from the union of MPWs, who felt that this would change the MPW's job description and add to their workload. Despite their involvement in informal discussions during the initial stages of the Project, the union leaders disrupted WCHP workshops and delayed the training agenda.

Although desirable, the participatory, bottom-up approach in planning and execution of activities like gender mainstreaming is very difficult to implement within large hierarchical structures. It appears that both the officers and the health care providers do not have much patience for process-oriented approaches, which require frequent meetings and discussions. It seems far easier to give top-down orders that can be mechanically implemented. The bureaucratic and hierarchical nature of the large public systems causes delays in decision-making and implementation of plans.

Some Achievements

Aspects of quality of care, like privacy for examining women and respectful and empathetic provider-client communication are being regularly monitored in the two project wards. The monitoring shows that most health care facilities have ensured privacy and are becoming increasingly conscious of the quality of their communication.

Some other decisions have had far-reaching and unexpected results. The decision to incorporate the gender module in all training provided in BMC has been successfully carried out. As a part of the government's new RCH Programme, a group of 20 Key Trainers have been trained within BMC. Many of these are persons who attended the senior officers' gender sensitisation workshop. To enhance their skills, WCHP organised a five-day workshop for them in the use of participatory training methodologies. In addition, WCHP's training modules on Gender, Men's Involvement, IEC, Provider-Client Communication, Quality of Care, etc., have been accepted and incorporated by the Key Trainers into the final training schedule for Mumbai's RCH Programme.

The WCHP has also provided input into the National Urban RCH Programme. In a meeting organised by the National Institute of Health and Family Welfare in 2000, the Maharashtra State RCH Coordinator and the WCHP Project Coordinator (who is also the Medical Officer in charge of the Training Cell in BMC) were invited to present their views on the training of Urban RCH. Their presentation was based on the learnings derived from the training conducted by WCHP, and included the curriculum for each cadre of health care providers, along with recommendations for the duration of training. Through their critique, the Project representatives were able to get infertility, care for elderly persons (geriatrics), gender, quality assurance, referral system and provider-patient communication, accepted into the curriculum of medical officers and health-workers at the level of primary care.

Implications for the National Health Programme

A review of 10 RCH manuals produced by the National Institute of Health

and Family Welfare for training MHWs, male health supervisors, medical officers in charge of PHCs, and ANMs revealed that the concept of gender and how gender issues affect the reproductive health of men and women, is completely missing from the content of the manuals (NIFHW 1998). The training content that the manuals include is also quite gender blind. The BMC experience of gender sensitisation may go some way in throwing light at gender sensitisation in a public health system in India.

Some of the experiences of gender mainstreaming within BMC's Public Health Department can be summarised as follows:

- there is growing recognition and understanding of how socially-defined roles impair women's health, in addition to the inadequate attention to their biologically based needs. There is also an increasing appreciation of how gender attitudes can sometimes adversely affect men's health.
- this may be the right time in the process to review gender sensitisation efforts and to develop a systematic gender mainstreaming strategy with key persons within the system. The introduction of the RCH Programme and other health sector reforms provides an ideal opportunity to ensure that the new frameworks and mechanisms being put in place include gender as an explicit and integral component of the health system.
- political will at high levels and support from key officials and administrators are essential to bring about systemic change. Along with this, responsibility for pushing the change has to be invested in a focal person within the system. Indicators for monitoring gender mainstreaming have to be evolved right at the beginning and reviewed periodically at the highest levels.

In short, mainstreaming of gender in the health sector is a process rather than a product, aimed at the overall goal of improving equity for women. Consequently, its full impact will necessarily take some years to establish. The lessons learnt from BMC can probably be fruitfully applied to the National Health System.

Notes

- 1 Even taking into account the worldwide difference found between TB prevalence in men and women, the ratio of 3:1 is too large to be explained by biological differences.
- 2 PID ANMs refer to the ANMs who were seconded full-time to the PID Project between 1993 and 1997. These ANMs went through an intensive training process described elsewhere (Khandekar, S. et al. 2000).
WCHP ward ANMs are ANMs who are working in the two wards in which the WCHP is being implemented.
Control ward ANMs are ANMs working in areas which have received only routine in-service training provided by the Public Health Department.

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*Chapter 37***Gender Mainstreaming
The CHETNA Experience**

Jyoti Gade and the CHETNA Team

Gender mainstreaming implies the integration of gender concerns into policies, programmes and projects, with the aim of enabling gender equity and equality. It is a strategy that situates gender equity and equality issues at the centre of policy decisions, institutional mechanisms and resource allocations. Further, it ensures that women's perspectives and voices are part of all development efforts. Gender mainstreaming requires a strategic approach for addressing the technical, organisational and institutional-level capacity building needs (Box 37.1).

The mission of the Centre for Health Education, Training and Nutrition Awareness (CHETNA), whose activities were initiated in 1980, is to contribute towards the empowerment of disadvantaged women, adolescents and children, so as to enable them to gain control over their own, their family's and community's health. It believes that empowerment leads to both gender equity and equality.

CHETNA's experiences over two decades have shown that training for building capacity followed by support at the field level and

Box 37.1**Approach for Gender Mainstreaming**

Technical level: Incorporate a gender perspective into programme planning, implementation, monitoring, budgeting and resource allocation.

Organisational level: Formulate an organisational policy that is gender sensitive.

Institutional level: Once a policy on gender and women's health is in place, mechanisms are required for its effective implementation. In order to evolve evidence-based strategies, it is necessary to create, collect and analyse gender-disaggregated data.

widespread dissemination of relevant information in local languages is critical for strengthening the capacities of the field-level functionaries to implement gender-sensitive programmes.

Sensitisation of policy-makers is vital for transforming mindsets, changing attitudes and for reducing the gender gap in the conceptualisation and delivery of primary health care services (UNFPA 2001). Gender training is an important intervention that can contribute substantially to the gender mainstreaming process, in which CHETNA is actively involved.

Specific Activities

Training

CHETNA holds training programmes for both NGO and GO leaders. These trainings are participatory and conducted at two or three levels, i.e., for organizational leaders and department heads, and supervisory functionaries.

- The training of leaders is conducted with the objective of helping them build a gender perspective on women's health by using a life cycle approach, and to ensure its integration in their policies, programme and projects.
- The training for middle-level workers is conducted to build their skills

for integrating gender-sensitive approaches at the implementation and monitoring levels. This includes the development of gender-sensitive indicators for monitoring and evaluation to determine the measure of gender integration at the project and programme level.

- Extensive field-level support is provided to the participants through visits, technical assistance and reference material distributed during events organised for the purpose of gender sensitisation. Whenever required, short-term orientation trainings are also organised.

The focus is on equipping policy-makers and health practitioners with the perspective, knowledge and skills for gender analysis.

Documentation

CHETNA conducts its capacity-building trainings mainly in the states of Gujarat, Rajasthan and some parts of Madhya Pradesh. However, in order to share its approach with a wider constituency, CHETNA documents all its training experiences in Gujarati, Hindi and English. These are then disseminated so that others can replicate or adapt them to suit their needs.

For example, CHETNA developed a manual on *Women's Health Towards Empowerment*, that is applicable at all three levels — village, district and state. It contains 30 comprehensive chapters on diverse aspects of women's health written from a gender perspective. The manual has been translated into eight languages for self-help groups in 13 states of India.

Development and Dissemination of IEC Materials

Based on the need, and after extensive field-testing, education and training materials are designed and developed for creating awareness at the community level and for sensitising policy-makers. For instance, *Women's Health: Towards Empowerment* is a perspective booklet; *Status Paper on Women and Men in Gujarat and Rajasthan* highlights the disparities and status of men and women to help in appropriate planning and action for a gender-sensitive programme; a set of 10 pamphlets to understand the concept of gender and health, covers such topics as *Anaemia*, *HIV/AIDS*, *Women's Health and Healing*, *Indigenous Health Practices*.

A manual on Gender Indicators to ensure the measurement of the integration of gender perspective in reproductive and women's health programmes was also developed for policy-makers and programme managers. (All materials are available from CHETNA in three languages: Hindi Gujarati and English.)

Networking and Advocacy

CHETNA is actively involved in organising events like seminars and workshops for policy- and decision-makers. These are aimed at bringing about a change in attitudes and mindsets, which, it is hoped, will ultimately lead to change in behaviour. To achieve this, CHETNA collaborates with strategic allies to advocate for gender issues.

CHETNA is also a member of various national and international networks and uses these alliances to promote gender integration and gender equality through a life cycle approach. These networks also provide opportunities to build links and facilitate exchanges between new and existing groups, individuals and other networks to disseminate information at a wider level and build pressure to bring about changes at the policy level.

Learnings

- An important principle in mainstreaming gender is the recognition of 'affirmative action' that is based on principles of equality and equity. This is a process that aims to correct historical wrongs. Since society has socially and culturally discriminated against women and minorities, institutionalised mechanisms need to be created to bring about equality and justice.
- It is important to remember that merely acknowledging the 'gender' inequalities between men and women is not enough. The situation will not change until all other forms of hierarchies, such as caste, class, ethnicity and race, are challenged.
- Women's lives, experiences, needs and interests need to be interwoven into the fabric of all organisations. This demands a process of greater democratisation, support systems, increased access and

control over resources by women, and enhancing women's leadership skills.

- Influencing key stakeholders at the family level is very important. These include men and other family members, and decision-makers in other institutions, such as religious and community leaders, policy-makers and politicians.
- Mainstreaming is a political process that changes power relations within organisations. It requires appropriate resource allocation (material, financial, human resources and time).
- The process of gender mainstreaming is a slow one. Perseverance, patience and support are therefore needed to bring about the necessary attitudinal change.
- The change process must ensure that communication channels are open at all levels. Transparency and openness are needed to encourage new thinking.
- Change must be at both qualitative and quantitative levels. A firm commitment of resources and time is of the essence to achieve this goal.
- An important element in mainstreaming is to make gender policies visible both within and outside the organisation through newsletters, group discussions, meetings, informal gatherings, etc.
- The process of mainstreaming is holistic. It cannot be compartmentalised. All issues and processes are intertwined and each affects the other. Thus, making fragmentary changes in an organisation will not be of much help. The cyclical process that is unleashed will have an impact on many dimensions.

Recommendations

- GOs and NGOs should allocate appropriate resources for gender mainstreaming, including material, financial, human resources and time.
- Change is a complex process. There is always resistance to it. The

form this resistance takes must be understood and dealt with through persuasion. A 'political will' for change needs to be created amongst all key stakeholders and all members need to be supported and involved in the change.

- A key factor is the commitment of the 'top leadership' to the process. In addition, a broad consensus in the organisation needs to be created and everyone needs to be involved in this collective process.
- 'Culture' is often used to prevent women from accessing their rights. Cultural practices that constrain women and deny them their rights need to be identified. Creating awareness about these among various key stakeholders is crucial.
- Appropriate Information, Education and Communication (IEC) material should be developed by the Government of India with the help of experienced NGOs in this field. The IEC material should have a balanced perspective and focus on disseminating messages on gender equality addressed to women. Reference material should also be developed at all levels, such as for policy-makers, implementers and the larger community. School textbooks also need to be made more gender-sensitive.
- Most GOs have recognised the importance of gender integration in their programmes and they are organising workshops, seminars and trainings for this purpose. Such events need to be systematically followed up.
- Gender is frequently considered to be a women's issue and it is mostly women who participate in gender-related events. GOs and NGOs must therefore emphasise the role of men in achieving gender equality and should make extra efforts to ensure their participation and support in the gender equality process.

We must remember that gender mainstreaming is critical for bringing about gender equity and equality. It must be ensured at all levels and aimed at diverse stakeholders if it is to lead to a gender-just society.

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The Women and Health (WAH!) initiative emerged out of a concern that the primary health care concept failed to consider gender issues and the specific health needs of women in the provision of health care. The WAH! programme began with a focus on training, and expanded over the years to include the goals of advocacy and networking, important especially in the context of the rapid changes taking place at both the macro and micro levels.

This volume of edited papers is a result of a collective process which culminated in a national consultation organised by the WAH! collective. The consultation was only the starting point for the book - several chapters and sections were added onto the papers presented at the consultation.

This volume is divided into two major sections. Section I consists of grassroots experiences and perspectives and Section II analyses various policies from the standpoint of how they affect women's health. Each section is further sub-divided into areas of emphasis that offer insights for a fuller understanding of issues.

The front cover is a montage of THE BRIDAL GOWN (reverse painting : watercolour & enamel on mylar, 204 X 153cm.) and HIEROGLYPHS, LOHAR CHAWL (watercolour on papier d' Arches, 76X61 cm.) executed by **NALINI MALANI** in 1994-95 and 1989 respectively.

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